| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056159 | A. Building<br>B. Wing | 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sherman Village Hcc | 12750 Riverside Drive<br>North Hollywood, CA 91607 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244<br><br>Based on observation, interview, and record review the facility failed to ensure residents were treated with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life by failing to ensure Restorative Nurse Aide 1 (RNA 1) did not provide feeding assistance simultaneously to two residents for two of ten residents (Resident 6 and 49) observed during the dining task.<br><br>This deficient practice had the potential to result in a decrease in psychosocial well-being for Residents 6 and 49.<br><br>Findings:<br><br>a. During a review of Resident 6's Admission Record, the Admission Record indicated the facility admitted the resident on 9/13/2021 with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), signs and symptoms concerning food and fluid intake, and muscle weakness.<br><br>During a review of Resident 6's Minimum Data Set (MDS - an assessment and care screening tool) dated 6/24/2024, the MDS indicated the resident sometimes was able to understand others and sometimes was able to make herself understood. The MDS indicated the resident was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.<br><br>During a review of Resident 6's Care Plan (CP) titled, (Resident 6) has alteration in nutritional status . initiated 9/13/2021, the CP indicated to have the resident up in the chair in the dining room at mealtime, to assist and give verbal cues while dining, to allow enough time to eat, to observe for chewing and swallowing difficulties, and to encourage adequate intake as tolerated.<br><br>b. During a review of Resident 49's Admission Record, the Admission Record indicated the facility admitted the resident on 7/21/2021 with diagnoses that included encephalopathy (a change in the brain function due to injury or disease), dysphagia (difficulty eating), dementia, and traumatic brain injury (TBI, a brain injury that is caused by an outside force).<br><br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 49's MDS, dated [DATE], the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make himself understood. The MDS indicated the resident was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.<br><br>During a review of Resident 49's CP titled, Resident has limitation in: strength, range of motion and ability to feed himself . initiated 12/3/2021, the CP indicated to provide restorative nursing aide feeding program (RNA, certified nursing aide program that helps residents to maintain their function).<br><br>During a Dining observation on 9/3/2024 12:06 p.m., observed Resident 6 and Resident 49 sitting at a shared table in the dining room. Observed Restorative Nurse Aide 1 (RNA 1) pull up a chair and sat between Resident 6 and 49. Observed RNA 1 pick up Resident 6's spoon and assisted the resident with feeding. Observed RNA 1 then put down Resident 6's spoon and pick up Resident 49's spoon and assisted the Resident 49 with feeding. RNA 1 continued to alternate between feeding both residents simultaneously until another staff member sat and continued to assist Resident 6 with feeding.<br><br>During a follow up interview on 9/3/2024 at 12:29 p.m., with RNA 1, RNA 1 stated he went back and forth between feeding Resident 6 and 49 because he did not want to make Resident 6 wait for him to finish assisting Resident 49 with his meal. RNA 1 stated he fed both residents at the same time for Resident 6's dignity, so she would not have to wait and watch him assist Resident 49.<br><br>During a concurrent interview and record review on 9/5/2024 at 1:50 p.m., with the Director of Nursing (DON), the DON reviewed the facility policies regarding feeding assistance and dignity. The DON stated it actually created a dignity issue to feed more than one resident at a time. The DON stated the facility policy is to feed one resident at a time without distractions. The DON stated feeding two residents at the same time is like feeding children and the RNA should provide individualized care and set aside time for one resident at a time. The DON stated one staff member should not be shared between residents during dining.<br><br>During a review of the facility policy and procedure titled, Assistance with Meals, last reviewed 7/25/2024, the policy indicated residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Facility staff will serve resident trays and will help residents who require assistance with eating. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity.<br><br>During a review of the facility policy and procedure titled, Dignity, last reviewed 7/25/2024, the policy indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-esteem. Residents are treated with respect and dignity at all times. When assisting with care, residents are supported in exercising their right. For example, residents are provided with a dignified dining experience. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>43988<br><br>Based on observation, interview, and record review:<br><br>1. The facility failed to ensure that the pad call light (a device with sensitive touch surface ideal for patients who may have difficulty using standard call cord to signal need for assistance from a professional staff) was within reach for three out of five sampled residents (Residents 3. 40, and 89) observed during random observations.<br><br>2. The facility failed to ensure the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach for one of eleven residents (Resident 19) investigated during review of the environment task.<br><br>This deficient practice had the potential to result in the delay of care and services and possible injury to residents when they are unable to ask assistance from facility staff.<br><br>Findings:<br><br>1. a. During a review of Resident 3's Admission Record, the Admission Record indicated the facility admitted the resident on 1/26/2016 and readmitted the resident on 9/22/2023 with diagnoses including but not limited to chronic respiratory failure (a long-term condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and epilepsy (a brain condition that causes recurring seizures [abnormal electrical activity in your brain]).<br><br>During a review of Resident 3's History and Physical (H&P) dated 9/27/2023, the H&P indicated the resident was non-verbal, non-communicative, and not aware of surroundings.<br><br>During a review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/4/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 3 had impairment on both upper and lower extremities.<br><br>During a review of Resident 134's fall risk assessments dated 9/22/2023, 12/29/2023, 4/8/2024, and 6/18/2024, the fall risk assessments indicated the resident was a high risk for falls.<br><br>During a review of Resident 3's care plan (CP), the CP on self-care deficits and needs total assistance in ADLs last revised 4/14/2024 with target date 9/15/2024, the CP indicated to place call light within reach and attend needs promptly as one of the interventions.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 9/3/2024 at 11:18 a.m., inside resident 3's room with Registered Nurse 2 (RN 2), observed the resident's pad call light on the left upper most part of the resident's bed, not within the resident's reach. RN 2 stated Resident 3 had contracture of both upper extremities and the call light should be within reach of the resident so the resident would be able to call staff if assistance was needed.<br><br>During an interview on 9/6/2024 at 2:50 p.m., with the Director of Nursing (DON), the DON stated the pad call light should be within reach so Resident 3 would be able to call for assistance if needed and staff would be able to promptly meet the resident's needs.<br><br>During a review of the facility's policy and procedure (P&P) titled, Call Lights, last reviewed 7/25/2024, the P&P indicated the following nursing care and duties of the staff:<br><br>-Ensure call light is within the resident's reach when in the room or in the toilet.<br><br>-Monitor the lights and ensure lights are answered promptly, regardless of who is assigned to each resident.<br><br>1.b. During a review of Resident 40's Admission Record, the Admission Record indicated the facility admitted the resident on 2/14/2020 and readmitted the resident on 2/7/2024 with diagnoses including but not limited to chronic respiratory failure (a long-term condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and traumatic brain injury (TBI - a brain injury resulting from a violent blow or jolt to the head or body).<br><br>During a review of Resident 40's History and Physical (H&P) dated 4/1/2024, indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 40's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/30/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 40 had impairment on both upper and lower extremities.<br><br>During a review of Resident 40's fall risk assessments dated 2/7/2024, 2/28/2024, 5/30/2024, and 9/5/2024, the fall risk assessments indicated the resident was a high risk for falls.<br><br>During a review of Resident 40's care plan (CP) on risk for unavoidable declines related to but not limited to cognitive deficits, muscle weakness, and poor safety awareness last revised 8/22/2024 with target date 11/28/2024, the PP indicated to place call light within reach and attend needs promptly as one of the interventions.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 9/3/2024 at 10:34 a.m. a.m., inside Resident 40's room with Registered Nurse 2 (RN 2), observed the resident's call light on the left side of the bed, not touching any part of the resident's body. RN 2 stated Resident 40's pad call light was not within reach of the resident because the resident cannot move. RN 2 stated the call light should be within reach so the resident can call for assistance if needed. RN 2 stated if the call light was not within reach, staff would be unable to assist and meet the resident's needs.<br><br>During an interview on 9/5/2024 at 2:50 p.m., with the Director of Nursing (DON), the DON stated the pad call light should be within reach of Resident 40 so the resident would be able to call for assistance if needed and staff would be able to promptly meet the resident's needs.<br><br>During a review of the facility's policy and procedure (P&P) titled, Call Lights, last reviewed 7/25/2024, the P&P indicated the following nursing care and duties of the staff:<br><br>-Ensure call light is within the resident's reach when in the room or in the toilet.<br><br>-Monitor the lights and ensure lights are answered promptly, regardless of who is assigned to each resident.<br><br>1.c. During a review of Resident 89's Admission Record, the Admission Record indicated the facility admitted the resident on 7/24/2024 with diagnoses including but not limited to acute respiratory failure (a condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and generalized muscle weakness.<br><br>During a review of Resident 89's History and Physical (H&P) dated 7/25/2024, indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 89's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/30/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 89 had impairment on both upper extremities.<br><br>During a review of Resident 89's fall risk assessments dated 7/25/2024, the fall risk assessments indicated the resident was a high risk for falls.<br><br>During a review of Resident 89's care plan (CP), the CP on risk for falls/injury related to but not limited to general weakness, impaired cognition, and poor safety awareness last revised 8/13/2024 with target date 11/26/2024 indicated to place call light within reach and attend needs promptly as one of the interventions.<br><br>During a concurrent observation and interview on 9/3/2024 at 9:58 a.m. a.m., inside Resident 89's room with Registered Nurse 2 (RN 2), observed the resident's call light on the left side of the bed, not touching any part of the resident's body. RN 2 stated Resident 89's pad call light was not within reach because the resident cannot move. RN 2 stated the call light should be within reach so the resident can call for assistance if needed. RN 2 stated if the call light was not within reach, the staff would be unable to assist and meet the resident's needs.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 9/5/2024 at 2:50 p.m., with the Director of Nursing (DON), the DON stated the pad call light should be within reach of Resident 89 so the resident would be able to call for assistance if needed and staff would be able to promptly meet the resident's needs.<br><br>During a review of the facility's policy and procedure (P&P) titled, Call Lights, last reviewed 7/25/2024, the P&P indicated the following nursing care and duties of the staff:<br><br>-Ensure call light is within the resident's reach when in the room or in the toilet.<br><br>-Monitor the lights and ensure lights are answered promptly, regardless of who is assigned to each resident.<br><br>44244<br><br>2. During a review of Resident 19's Admission Record, the Admission Record indicated the facility admitted the resident on 8/9/2024 with diagnoses that included necrosis (death of body tissue) of right femur (the thigh bone), disorder of bone density (measure of minerals in bone that determines the strength of the bone) and structure, difficulty walking, muscle weakness, mild cognitive impairment (early stage of memory loss) and need for assistance with personal care.<br><br>During a review of Resident 19's Minimum Data Set (MDS - an assessment and care screening tool) dated 8/16/2024, the MDS indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS indicated the resident required substantial/maximal assistance from staff for toileting, bathing, and dressing; and required partial/moderate assistance from staff for personal hygiene, oral hygiene, moving from sit to stand, and transferring from the chair to bed.<br><br>During a review of Resident 19's Care Plan (CP) titled, Resident is at risk for falls/injury related to gen (generalized) weakness, impaired cognition, osteoporosis (decreased thickness of bone tissue), poor body balance/control, poor safety awareness/judgement, initiated 8/30/2024, the CP indicated to provide the resident with a safe environment and to keep the call light within easy reach and encourage the resident to use it to get assistance.<br><br>During a review of Resident 19's CP titled, Resident has self-care deficit, initiated 8/30/2024, the CP indicated to provide a safe environment and to keep the call light within reach and attend needs promptly.<br><br>During an observation and interview on 9/3/2024 at 10:15 a.m., Resident 19 sat in a wheelchair (WC) on the left side of the bed, no staff were present in the room. Resident 19 stated she had been sitting next to the bed for about a half an hour after returning from physical therapy. Resident 19 stated she needed assistance to move in the WC. Observe Resident 19's call light attached to the right upper side rail of the bed. Observed the call light was not within reach.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 9/3/2024 at 10:20 a.m., observed Certified Nursing Assistant 5 (CNA 5) entered Resident 19's room. CNA 5 stated Resident 19 had returned from rehabilitation (rehab, physical therapy), and the rehab staff did not notify him the resident was back. CNA 5 stated Resident 19's call light was on the far side of the bed and not within reach of the resident. CNA 5 stated the call light should be within reach of the resident. CNA 5 stated the staff that brought the resident back from rehab should have placed the call light next to the resident and they did not.<br><br>During a concurrent interview and record review on 9/5/2024 at 1:50 p.m., with the Director of Nursing (DON), the DON reviewed the facility policy on call lights. The DON stated the call light should always be within reach of the resident. The DON stated the rehab staff should have placed Resident 19's call light next to her before leaving the room. The DON stated the purpose of the call light is for staff to be able to attend to the resident's needs. The DON stated staff are assigned to multiple residents and cannot always be with a resident, so the call light provides a way to call staff. The DON stated if the call light is not within reach of the resident, there is a potential for a delay in attending to the resident's needs that may result in emotional distress in the resident and there is also a potential for accidents.<br><br>During a review of the facility policy and procedure titled, Call Lights, last reviewed 7/25/2024, the policy indicated call lights assure residents receive prompt assistance. All staff shall know how to place the call light for a resident and how to use the call light system. Nursing and care duties include insuring that the call light is within the resident's reach when in his/her room.<br><br>During a review of the facility policy and procedure titled, Falls and Fall Risk, Managing, last reviewed 7/25/2024, the policy indicated based on evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling. |

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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418<br><br>Based on observation, interview, and record review, the facility failed to promote the resident rights to examine the results of the state inspection results (a survey to determine compliance with state and federal regulations) of the facility by failing to post survey results in a place that is prominent and accessible (a place where individuals wishing to examine survey results do not have to ask to see them) to residents, family members, and legal representatives of residents.<br><br>This deficient practice had the potential for residents' and their representative not having access to examine the most recent survey results.<br><br>Findings:<br><br>During a review of Resident 13's Admission Record, the Admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses including, but not limited to, difficulty walking and generalized muscle weakness.<br><br>During a review of Resident 13's Minimum Data Set (MDS - a standardized assessment and care screening too), dated 8/5/2024, the MDS indicated Resident 13 was able to understand and make decisions, was able to eat independently and required moderate assistance for activities of daily living, including hygiene, dressing, surface-to-surface transfers, and walking 10 feet.<br><br>During a review of Resident 13's History and Physical (H&P), dated 7/30/2024, the H&P indicated Resident 13 has the capacity to understand and make decisions.<br><br>During an interview, on 9/4/2024, at 10:07 a.m., six out of six resident council group attendees (Resident 13, 195, 23, 39, 346, and 42) stated they were not aware of where to find the state inspection results.<br><br>During an interview with the Assistant Activities Director (AAD), on 9/4/2024, at 10:50 a.m., the AAD stated she did not know where to find the survey binder and that she was not oriented to where its location is.<br><br>During a concurrent observation and interview, on 9/4/2024, at 10:54 a.m., with Resident 13, in front of Nursing Station A, a large white binder containing documents was inside a wall mounted holster approximately five feet above the floor. A sign above the holster indicated the binder contained the state inspection results. Resident 13 sat in a wheelchair in front of the binder and attempted to reach and remove the binder from the holster however was not able to remove the binder. Resident 13 stated the binder was too heavy and placed too high for her to take the binder out of the holster without having to ask for help.<br><br>During an interview with the Director of Nursing (DON), on 9/6/2024, at 2:01 p.m., the DON stated the state inspection results should be placed in an area that is unobstructed and easy to access. The DON stated it the residents' right and if they did not have access to the state inspection results, the residents and visitors would not know what is going on in the facility.<br><br>(continued on next page) |

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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review the of facility's policy and procedure (P&P) titled, Resident Rights, last reviewed 7/25/2024, the P&P indicated the facility must make sure the results of the most recent survey are in a place readily accessible to residents and must post a notice of their availability. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244<br><br>Based on observation, interview, and record review, the facility failed to provide a homelike environment by failing to:<br><br>1. Ensure the residents bathroom flooring under the shower chair was in good repair for one of five sampled residents (Resident 42) investigated during review of accidents care area.<br><br>2. Place a flat sheet on the mattress while the resident was lying in bed for one of three sampled residents (Resident 62) investigated during review of pressure ulcer (also called pressure injuries and decubitus ulcers - injuries to skin and underlying tissue resulting from prolonged pressure on the skin) care area and one of one sampled residents (Resident 80) investigated during review of general care area.<br><br>3. Maintain the cleanliness of resident desk fans for one of four randomly observed residents (Resident 68).<br><br>These deficient practices had the potential to negatively affect the resident's psychosocial wellbeing and make the residents feel uncomfortable in their living space.<br><br>Cross reference to F686 nad F689.<br><br>Findings:<br><br>1.During a review of Resident 42's Admission Record, the Admission Record indicated the facility admitted the resident on 4/13/2024 with diagnoses that included encephalopathy (a change in the brain function due to injury or disease), unspecified mood disorder (mental health condition marked by disruptions in emotions [severe lows called depression or highs called hypomania or mania]), difficulty walking, muscle weakness, acquired absence of the right leg below the knee, and traumatic brain injury (a brain injury that is caused by an outside force).<br><br>During a review of Resident 42's Minimum Data Set (MDS - an assessment and care screening tool) dated 7/11/2024, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS indicated the resident required partial/moderate assistance from staff for toileting, dressing, personal hygiene, moving from sit to stand, transferring from the chair to bed, and toilet transfers.<br><br>During a review of Resident 42's Care Plan (CP) titled, Resident is at risk for falls/injury related to difficulty walking, gen. (generalized) weakness, poor body balance / control, initiated 5/24/2024, the CP indicated to provide the resident with a safe environment.<br><br>During a review of Resident 42's CP titled, Resident claimed he bumped his right shoulder against the bathroom wall, initiated 8/22/2024, the CP indicated a goal to minimize the risk of injury to the resident.<br><br>(continued on next page) |

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| | 056159 | A. Building<br>B. Wing | 09/06/2024 |

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| Sherman Village Hcc | 12750 Riverside Drive<br>North Hollywood, CA 91607 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 9/3/2024 at 9 a.m., with Resident 42, observed the resident sitting in his wheelchair and stated he has an amputation on his right leg and uses a shower chair placed over the toilet because it is easier for him to make transfers and to use the toilet. Resident 42 stated he hit his back when the shower chair had become unstable during a transfer. Resident 42 stated there was a broken piece of flooring under the wheel of the shower chair. Observed in Resident 42's restroom, a blue shower chair with the back wheel on top of a broken piece of laminate flooring.<br><br>During a concurrent interview and observation on 9/3/2024 at 9:15 a.m., Licensed Vocational Nurse 3 (LVN 3) entered Resident 42's restroom and stated the laminate flooring under the wheel of the shower chair is broken.<br><br>During an observation on 9/4/2024 at 12:02 p.m., observed Resident 42's restroom with the shower chair back wheel on top of a broken piece of laminate flooring.<br><br>During an interview on 9/4/2024 at 12:03 p.m., LVN 3 stated he reported Resident 42's broken piece of laminate flooring to the Maintenance Supervisor (MS) on 9/3/2024.<br><br>During a concurrent interview and observation on 9/4/2024 at 12:06 p.m., the MS entered Resident 42's restroom and stated the laminate flooring was broken and was probably not safe for Resident 42's shower chair to be placed on top of it. The MS stated nobody had reported the flooring issues to him on 9/3/2024.<br><br>During a concurrent interview and record review on 9/5/2024 at 1:50 p.m., with the Director of Nursing (DON), reviewed the facility policy regarding homelike environment and building maintenance. The DON stated it was not a homelike environment or safe for Resident 42's shower chair to be placed over the broken flooring because it could cause the shower chair to become unstable resulting in injury to the resident. The DON stated the broken flooring should have been reported to maintenance to be repaired, but it was not. The DON stated the facility's policy was not followed because the flooring was not assessed for safety in a timely manner.<br><br>During a review of the facility policy and procedure regarding cleaning of the facility, last reviewed 7/25/2024, the policy indicated in order to ensure the health and safety of residents, staff and visitors, it is critical that the facility be kept clean, sanitary, and in good repair at all times.<br><br>During a review of the facility policy and procedure titled, Homelike Environment, last reviewed 7/25/2024, the policy indicated residents are provided with a safe, clean, comfortable, and homelike environment. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting.<br><br>[Cross Reference F689]<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. a. During a review of Resident 80's Admission Record, the Admission Record indicated the facility admitted the resident on 4/3/2024 and readmitted the resident on 5/10/2024 with diagnoses that included frontal lobe (largest part of the brain) and executive function (skills used to manage everyday tasks) deficit (lack of) following nontraumatic intracerebral hemorrhage (a stroke, loss of blood flow to part of the brain which damages brain tissue), gastrostomy (G-tube or GT, a tube placed directly into the stomach to give direct access for supplemental feeding, hydration or medicine), difficulty walking, and muscle weakness.<br><br>During a review of Resident 80's MDS dated [DATE], the MDS indicated the resident was rarely/never able to understand others and was rarely/never able to make himself understood. The MDS indicated the resident required substantial/maximal assistance from staff for oral hygiene, toileting, bathing, and dressing, personal hygiene, and mobility.<br><br>During a review of Resident 80's Physician Orders Summary Report, the report indicated orders for the following:<br><br>- Pressure Reducing Mattress (PRM, designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) for skin prevention management, dated 6/3/2024.<br><br>During a review of Resident 80's Care Plan (CP) titled, Skin integrity impairment secondary to eczema (disease that causes inflammation, redness, and irritation of the skin), initiated 5/10/2024, the CP indicated to keep the resident clean and dry.<br><br>During an interview on 9/3/2024 at 2 p.m., Family Member 1 (FM 1) stated Resident 80 had a rash that was not healing.<br><br>During an observation on 9/3/2024 at 12:31 p.m., Resident 80 lay in bed, observed the resident lying on a PRM. Observed there was no flat sheet on the mattress and the resident lay on a small pad placed between his bottom and lower torso and the mattresses plastic covering. Observed the residents upper back, legs, and arms came into direct contact with the plastic mattress cover.<br><br>During a concurrent observation and interview on 9/5/2024 at 9:46 a.m., with Treatment Nurse 1 (TX 1) and Registered Nurse 3 (RN 3), TX 1 stated Resident 80 was being seen by the dermatologist for a rash. TX 1 stated Resident 80 was laying on a PRM without a sheet and his torso did touch the plastic covering of the PRM. TX 1 stated the facility had flat sheets for the PRMs, but the facility did not allow more than two layers on the PRM. TX 1 stated the two layers may include only two of the following: a sheet, an absorbent pad, or an adult brief. TX 1 stated the resident wore an adult brief and was on top of an absorbent pad and they could not add a sheet because it would be a third layer. TX 1 stated she would not like to be on the plastic of the PRM without a sheet because it would not be comfortable. TX 1 stated not having a sheet may not be a homelike environment. RN 3 stated it did not really seem homelike to be directly on the plastic cover without a sheet.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 9/5/2024 at 1:50 p.m., the Director of Nursing reviewed the facility policy and procedure regarding homelike environment and PRMs. The DON stated the facility is responsible for providing linens for residents. The DON stated it wasn't very homelike to not provide a sheet for the PRM, but they could not place more than two layers on top of the PRM. The DON reviewed the facility PRM policy and stated the policy indicated to place a flat sheet on the PRM and it should be provided and was not. The DON stated when sheets were not provided for Resident 80 there was the potential for emotional distress from not being provided a homelike environment.<br><br>During a review of the facility policy and procedure titled, Pressure-Reducing Mattresses, last reviewed 7/25/2024, the policy indicated to place a flat sheet over the mattress, while ensuring that no more than two layers of linen are between the resident and pressure reducing mattress. If a resident is incontinent, place a protective pad in the center of the bed (Remember this will count as one layer of linen! So, do not exceed two layers).<br><br>During a review of the facility policy and procedure titled, Homelike Environment, last reviewed 7/25/2024, the policy indicated residents are provided with a safe, clean, comfortable, and homelike environment. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean bed and bath linens.<br><br>43418<br><br>2.b. During a review of Resident 62's Admission Record, the Admission Record indicated the facility originally admitted Resident 62 on 6/18/2024 with diagnoses including, but not limited to, malignant neoplasm (also known as cancer, a disease in which abnormal cells divide uncontrollably and destroy body tissue) of the prostate (a gland in the male reproductive system) and secondary malignant neoplasm of the bone.<br><br>During a review of Resident 62's MDS, dated [DATE], the MDS indicated Resident 62 had difficulty understanding and making decisions, required maximal assistance or was dependent on staff for activities of daily living such as toileting, hygiene, dressing, bathing, or showering, and surface-to-surface transfers. The MDS further indicated Resident 62 had a deep tissue injury present on admission and was using a pressure reducing device for the bed.<br><br>During a review of Resident 62's Order Summary Report, dated 7/17/2024, the report indicated Resident 62 was ordered a low air loss mattress for wound care and management and to monitor the low air loss mattress for proper functioning.<br><br>During a review of Resident 62's Care Plan, last revised 6/25/2024, the care plan indicated Resident 62 had a sacrococcyx (the area of the body that includes the sacrum [large, triangular-shaped bone in the lower spine] bone and the tailbone) deep tissue injury with interventions including pressure relieving devices as needed.<br><br>During an observation on 9/3/2024, at 10:04 a.m., inside Resident 62's room, Resident 62 was sleeping on top of a LALM without a flat sheet placed between the resident and the mattress.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 9/5/2024, at 2:49 p.m., inside Resident 62's room, Resident 62 was sleeping in bed covered by a blanket. Resident 62's head was resting on a pillow and the section of the mattress at the head of the bed did not have a flat sheet between the pillow and mattress.<br><br>During an interview with Certified Nursing Assistant (CNA) 8, on 9/6/2024, at 11:57 a.m., CNA 8 stated she was assigned to Resident 62 and that Resident 62 was on a LALM. CNA 8 stated she changed Resident 62's beddings earlier and placed the resident on a pad and applied an incontinence brief. CNA 8 stated residents on LALM can only have two layers and the incontinence briefs and the pad count towards the two layers. CNA 8 stated if she placed a thin sheet on the LALM, she would have to remove either the incontinence brief or pad. CNA 8 further stated Resident 62's LALM did not have a flat sheet placed over the mattress and that Resident 62's arms and legs are touching the surface material on the LALM.<br><br>During an interview with Treatment Nurse (TX) 1, on 9/6/2024, at 1:28 p.m., TX 1 stated that she performs the wound treatments for Resident 62. TX 1 stated Resident 62's treatments include placing the resident on a LALM. TX 1 stated when residents are placed on a LALM, the facility uses two layers, which can be an incontinence brief, pad, and/or flat sheet. TX 1 stated when she administered Resident 62's treatment, she observed the resident with a pad and an incontinence brief. TX 1 stated Resident 62's LALM should have a flat sheet covering it because an exposed mattress does not look homelike. TX 1 further stated when a resident's environment does not look homelike, there is a potential for residents to feel uncomfortable.<br><br>During an interview with the Director of Nursing (DON), on 9/6/2024, at 2:01 p.m., the DON stated a flat sheet should be placed over a LALM to provide a homelike environment for residents. The DON further stated if a homelike environment is not provided for the residents, the residents can potentially feel uncomfortable.<br><br>During a review of the facility's policy and procedure (P&P) titled, Pressure-Reducing Mattresses, last reviewed 7/25/2024, the P&P indicated to place a flat sheet over the mattress, while ensuring no more than two layers of linen are between resident and pressure reducing device.<br><br>During a review of the facility's P&P titled, Homelike Environment, last reviewed 7/25/2024, the P&P indicated the facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutionalized setting.<br><br>43988<br><br>3. During a review of Resident 68's Admission Record, the Admission Record indicated the facility admitted the resident on 8/7/2023 with diagnoses including but not limited to hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (also known as stroke, a condition that occurs when blood supply to part of the brain is blocked or reduced) affecting right dominant side, tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing) status, and generalized muscle weakness.<br><br>During a review of Resident 68's History and Physical (H&P) dated 8/7/2023, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 68's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).<br><br>During a concurrent observation and interview with Certified Nursing Assistant 2 (CNA 2), on 9/3/2024, at 10:49 a.m., inside Resident 68's room, CNA 2 confirmed the frame of the electrical fan placed on top of the overbed table by the foot of Resident 68's bed had strips of gray powder like material lining the outward frame. CNA 2 stated the gray powder like material on the fan is dust. CNA 2 stated housekeeping staff is responsible in cleaning any equipment or appliance in the facility.<br><br>During an interview on 9/3/2024 at 11;05 a.m., with the Maintenance Supervisor (MS), the MS stated the housekeeping department is responsible for making sure furnishings such as fans are kept clean.<br><br>During an interview on 9/6/2024 at 2;23 p.m., with the Housekeeping Supervisor (HS), the HS stated any furnishings in the resident room such as electrical fans are supposed to be cleaned once a month during the deep cleaning schedule of each room and/or as needed if any furnishings were observed as not clean. The HKS stated it is important to keep the fans clean for infection control.<br><br>During an interview on 9/6/2024 at 3:05 p.m., with the DON, the DON stated the housekeeping department is primarily responsible in maintaining cleanliness of any furnishings inside the resident room. The DON stated the housekeeping department has a monthly schedule of rooms for deep cleaning which include cleaning the furnishings such as fans. The DON stated all staff are responsible for maintaining cleanliness of any equipment in the resident's room, as dust can cause allergies. The DON further not providing a homelike environment affects the resident's dignity and quality of life.<br><br>During a review of the facility's policy and procedure (P&P) titled, Maintenance and Plant Operations, last reviewed 7/25/2024, the P&P indicated the facility will properly maintain the building, its fixtures, systems, and equipment to ensure that the entire facility is clean, free of environmental pollutants, and in good repair and safe operating conditions at all times.<br><br>During a review of the facility's P&P titled, Homelike Environment, last reviewed 7/25/2024, the P&P indicated residents are provided with a safe, clean, comfortable, and homelike environment. The policy indicated the staff and management maximizes the characteristics of the facility that reflect a personalized, homelike setting by providing a clean, sanitary, and orderly environment. |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418<br><br>Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body) for five of five sampled residents (Resident 37, 46, 79, 63, and 73) investigated during review of the physical restraints care area when the facility failed to:<br><br>1. Obtain a physician's order, perform an assessment, and obtain an informed consent (process in which residents or resident representatives are given important information, including possible risks and benefits, about a procedure or treatment) for use of pillows underneath the resident's mattress and use of bed rails (also known as side rails [SR], adjustable metal or rigid plastic bars that attach to the bed and are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths and may be positioned in various locations on the bed; upper or lower, either or both sides) for Resident 37.<br><br>2. Obtain a physician's order, assess the resident for bed entrapment, and obtain an informed consent for use of all four side rails in raised (up) position for Resident 46.<br><br>3. Obtain a physician's order and informed consent prior to using bilateral (two sides) upper (area including arms, shoulders, and head) and lower (area at the legs and feet) SR in raised (up) position for Resident 79.<br><br>4. Follow the physician's order to apply the hand mitten (a type of glove with a single part for all the fingers and a separate part for the thumb to prevent the patient from grasping and dislodging tubes and catheters) on the right hand and ensure the mitten was not applied too snug for Resident 63.<br><br>5. Follow the physician's order for bilateral upper half siderails up and locked while in bed for Resident 73.<br><br>These deficient practices had the potential for residents and their representatives to be unaware of the risks and benefits for use of restraints and for staff to be unaware of the necessity of restraint use, if it is safe to place residents on restraints, result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), death of residents, and violate the resident's rights to be free from any restraints that are imposed for reasons other than the treatment of the resident's medical symptoms.<br><br>Cross-reference F641, F656, and F700.<br><br>Findings:<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. During a review of Resident 37's Admission Record, the Admission Record indicated the facility originally admitted Resident 37 on 4/12/2019 and readmitted the resident on 6/27/2022, with diagnoses including, but not limited to, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures [a sudden, uncontrolled burst of electrical activity in the brain that can cause temporary changes in a person's behavior, movements, feelings, and level of awareness]).<br><br>During a review of Resident 37's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/24/2024, the MDS indicated Resident 37 was rarely or never understood, was dependent on staff for activities of daily living such as eating, hygiene, toileting, dressing, bathing, and surface-to-surface transfers. The MDS further indicated bed rails and other types of restraints were not used.<br><br>During a review of Resident 37's History and Physical, dated 8/7/2024, the H&P indicated Resident 37 did not have the capacity to understand and make decisions.<br><br>During an observation on 9/3/2024, at 10:07 a.m., inside Resident 37's room, Resident 37 was sleeping in bed, facing towards the resident's left side, towards the wall. Resident 37's bed was placed against the wall, in the far-right corner upon entry into the room, with the head of the bed pointing towards the room window, the foot of the bed pointing toward the doorway, and the left side of the bed against the wall. Resident 37's bed had two quarter rails on the head and foot of the right side of the bed. Resident 37's bed had pillows placed along the right side, under the mattress, and elevated the right side of the bed to slightly below the top of quarter rails.<br><br>During an observation on 9/5/2024, at 2:26 p.m., inside Resident 37's room, Resident 37 was sleeping in bed. Resident 37's bed had pillows placed underneath the right side of the mattress, creating an angled incline away from Resident 37's right side.<br><br>During a concurrent observation and interview with Restorative Nurse Aide (RNA) 2, on 9/5/2024, at 2:34 p. m., inside Resident 37's room, RNA 2 confirmed the presence of pillows underneath the right side of Resident 37's mattress and the bed rail at the right side of the head of the bed was up. RNA 2 stated Resident 37 is very active and makes attempts to jump out of the bed. RNA 2 stated Resident 37's certified nursing assistants (CNA) must have placed the pillows underneath the resident's mattress. RNA 2 further stated Resident 37's family sometimes puts the pillows under that mattress.<br><br>During an interview with Family Member (FM) 2, on 9/5/2024, at 2:53 p.m., FM 2 stated she is the family member of Resident 37 and prefers to have the pillows underneath the resident's mattress because the resident jumps out of the bed. FM 2 further stated she and the facility staff place the pillows underneath Resident 37's mattress.<br><br>During an interview with CNA 9, on 9/6/2024, at 9:07 a.m., CNA 9 stated she was assigned to Resident 37. CNA 9 stated Resident 37 attempts to jump out of his bed and pillows are placed underneath Resident 37's mattress to position his mattress at an angle so that the resident is more toward the wall of the room and to protect the resident.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview with the Minimum Data Set Coordinator (MDSC), on 9/6/2024, at 9:27 a.m., inside Resident 37's room, the MDSC confirmed Resident 37 had pillows placed underneath the right side of his mattress and that the pillows should not be placed there because it can be considered a restraint. The MDSC stated there have been instances where Resident 37 attempts to roll out of bed and the pillows placed under the mattress help keep him in place. The MDSC confirmed Resident 37 had quarter bed rails on the left and right side of his bed. The MDSC reviewed Resident 37's Order Summary Report, with orders active as of 9/6/2024, and confirmed Resident 37 did not have orders to place pillows underneath the resident's mattress and orders for use of bed rails and stated there should be orders in place to follow the plan of care and for the safety of the resident. The MDSC reviewed Resident 37's medical record and stated Resident 37 did not have an informed consent and assessment performed for the use of pillows underneath the mattress and for bed rails. The MDSC stated an assessment needs to be performed prior to the use of restraints to check if it is appropriate to use, to see if other less restrictive measures can be utilized, and to check for the safety of the resident. The MDSC stated it is important to provide residents and or their responsible persons with an informed consent so that they are aware of what is going to be used and the risks and benefits. The MDSC further stated if an informed consent was done in the past, it should still be placed in the current medical record.<br><br>During an interview with the Director of Nursing (DON), on 9/6/2024, at 2:01 p.m., the DON stated placing pillows underneath the mattress and side rails can be considered restraints. The DON stated when using restraints, an informed consent, an assessment, and physician's order is needed to inform the staff, resident, and responsible person of the intervention, to see if the restraint is needed or not, and to determine the safety of the resident. The DON stated even if the use of restraints is a family request, an informed consent, an assessment, and physician's order is needed. The DON stated informed consents inform the resident and the responsible person of the risks and benefits of the restrain being applied. The DON further stated Resident 37 did not have an order for the use of pillows underneath the mattress and bed rails.<br><br>During a review of the facility's policy and procedure (P&P) titled, Physical Restraint, last reviewed 7/25/2024, the P&P indicated the licensed nurse shall be responsible for obtaining an order from the attending physician which is to include the specific type of restraint, purpose of the restraint, time, and place of application, approaches to prevent decreased functioning when applicable, informed consent obtained from the resident or from the surrogate decision-maker. The P&P indicated the licensed nurse shall complete the informed consent acknowledgement form. The P&P further indicated licensed nurses are to document weekly in the licensed nurse's notes the use and effectiveness of physical restraints.<br><br>During a review of the facility's P&P titled, Bed Safety and Bed Rails, last reviewed 7/25/2024, the P&P indicated the use of bed or side rails is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.<br><br>44376<br><br>(continued on next page) |

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| | 056159 | A. Building<br>B. Wing | 09/06/2024 |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. During a review of Resident 46's Admission Record, the record indicated the facility admitted the resident on 10/3/2020, and readmitted the resident on 4/23/2024, with diagnoses including quadriplegia (a condition where all four limbs experience paralysis), seizures (a sudden, uncontrolled burst of electrical activity in the brain that can cause changes in behavior, movement, and awareness), and traumatic brain injury (a form of acquired brain injury, occurs when a sudden trauma causes damage to the brain).<br><br>During a review of Resident 46's History and Physical (H&P), dated 4/23/2024, the H&P indicated the resident was incapacitated and had muscle weakness with limited movement, and required visit for safety.<br><br>During a review of Resident 46's MDS, dated [DATE], the MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, the basic tasks people perform to care for themselves and stay healthy).<br><br>During a review of Resident 46's Order Summary Report, dated 4/23/2024, the report indicated an order to apply bilateral padded half siderails as seizure precaution to minimize risks of injury. Informed consent obtained from resident representative (RP) by MD after explanation of risks and benefits, every shift.<br><br>During a concurrent observation and interview on 9/3/2024, at 11:12 a.m., with CNA 1, inside Resident 46's room, observed Resident 46's all four side rails in raised position. CNA 1 stated placing all four side rails up is considered a restraint.<br><br>During a concurrent interview and record review on 9/4/2024, at 2:33 p.m., with Registered Nurse (RN) 1, reviewed Resident 46's Order Summary Report, consents, assessments, and care plans. RN 1 stated there is no physician's order, no consent from the resident or resident representative, no assessment for bed entrapment, and no care plan for use of all four side rails in raised position. RN 1 stated it is important to ensure there was a physician's order, an assessment for entrapment, a consent from the resident or resident representative, and a care plan for side rail use to ensure the resident's safety and to honor the resident's right to accept or decline the use of restraint.<br><br>During an interview on 9/6/2024, at 2:01 p.m., with the DON, the DON stated it is important to have a physician's order, a consent from the resident or resident representative, an assessment for entrapment, and a care plan for use of all four side rails to ensure the interventions are safe and appropriate and to honor resident's right to refuse treatment if desired.<br><br>During a review of the facility's recent P&P titled, Physical Restraint, last reviewed on 7/25/2024, the policy and procedure indicated physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body. The licensed nurse shall be responsible for obtaining an order from the attending physician which is to include:<br><br>a. Specific type of restraint.<br><br>b. Purpose of the restraint.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | c. Time and place of application.<br><br>d. Approaches to prevent decreased functioning when applicable.<br><br>e. Informed consent obtained from resident of from surrogate decision-maker.<br><br>During a review of the facility's P&P titled, Bed Safety and Bed Rails, last reviewed on 7/25/2024, the policy and procedure indicated before using bed rails for any reason, the staff shall inform the resident or resident representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent:<br><br>a. The assessed medical needs that will be addressed with the use of bed rails;<br><br>b. The resident's risk from the use of bed rails and how these will be mitigated;<br><br>h. The alternatives that were attempted but failed to meet the resident's needs; and<br><br>i. The alternatives that were considered but not attempted and the reasons.<br><br>44244<br><br>3. During a review of Resident 79's Admission Record, the Admission Record indicated the facility admitted the resident on 3/29/2024 and readmitted the resident on 4/26/2024 with diagnoses that included metabolic encephalopathy (a change in the brain function due to injury or disease), epilepsy, lack of coordination, muscle weakness, and anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear).<br><br>During a review of Resident 79's MDS, dated [DATE], the MDS indicated the resident required substantial/maximal assistance from staff rolling left and right, moving from sit to stand, and moving from lying to sitting on the side of the bed. The MDS further indicated the resident had a fall while in the facility.<br><br>During a review of Resident 79's Physician Orders Summary Report, the report indicated orders for the following:<br><br>- bilateral upper up SRs locked when in bed for activities of daily living changes, mobility, positioning, and as an enabler, (informed consent obtained from resident/responsible party after explanation of risk and benefits, and verified with physician), dated 7/31/2024.<br><br>- apply bilateral padded upper SRs as seizure precaution to minimize risks of injury. Informed consent obtained from resident representative by physician after explanation of risks and benefits, dated 4/26/2024.<br><br>-Super Star Program (a fall prevention program), frequent visual monitoring due to higher risk for fall and injury, document every shift, dated 8/8/2024.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 79's Informed Consent forms, dated 7/31/2024 and 5/22/2024, the forms indicated the resident representative provided consent for the use of bilateral upper SRs. The form did not indicate consent for bilateral lower SRs.<br><br>During a review of Resident 79's Care Plan (CP) titled, Side rail use as non-restraint. Resident is at risk for movement from bed to floor ., initiated 5/17/2024, the CP indicated a goal that the resident would be free of movement from the bed to floor.<br><br>During a review of Resident 79's CP titled, Resident is on .bilateral half upper side rails ., initiated 8/30/2024, the CP indicated a goal to prevent or reduce incident of injury/fall as well as for comfort of getting in and out of bed.<br><br>During an observation on 9/3/2024 at 2:15 p.m., observe Resident 79 in bed sleeping with bilateral upper and bilateral lower (all) SRs in the raised position.<br><br>During a concurrent observation and interview on 9/3/2024 at 3:50 p.m., Resident 79 lay in bed awake. Observe all SRs in the raised position. Resident 79 stated he did not like all the SRs up because he could not get up.<br><br>During a concurrent interview and record review on 9/3/2024 at 3:55 p.m., observed Licensed Vocational Nurse (LVN) 5 stood in Resident 79's doorway. LVN 5 stated Resident 79 had all SRs raised because the resident tries to get out of bed and had a history of falls.<br><br>During a concurrent observation and interview on 9/4/2024 at 2:54 p.m., CNA 5 observed Resident 79 and stated Resident 79 wants to get up and he tries to get up. CNA 5 stated the resident had all the SRs up to protect the resident from falling.<br><br>During a concurrent interview and record review on 9/4/2024 at 2:57 p.m., with LVN 3, reviewed Resident 79's physician orders. LVN 3 stated he cares for Resident 79 and the resident was supposed to have all four SRs up and he has a history of aggression. LVN 3 stated Resident 79 did not have a physician's order for bilateral upper and lower SRs, the resident only had an order for bilateral upper SRs. LVN 3 stated all SRs up is a restraint because it restricts the resident's movement. LVN 3 stated he should talk with the resident's doctor to decide if the resident needed a restraint, because the use of restraints required an order. LVN 3 stated restricting a resident's movement can be stressful over time.<br><br>During a concurrent interview and record review on 9/4/2024 at 3:06 p.m., with LVN 4, reviewed Resident 79's physician orders and informed consent forms. LVN 4 stated Resident 79 did not have a current order for bilateral upper and lower SRs. LVN 4 stated there was no documented evidence Informed Consent was obtained for the use of bilateral upper and lower SRs for Resident 79. LVN 4 stated the use of bilateral upper and lower SRs requires a physician's order and informed consent, but Resident 79 did not have them.<br><br>During an observation on 9/5/2024 at 9:10 a.m., observe Resident 79 in bed, awake, with bilateral upper and lower SRs in the raised position.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 9/5/2024 at 9:20 a.m., observed RN 3 enter Resident 79's room and lowered the bilateral lower SRs. RN 3 stated Resident 79 should not have all four SRs in the raised position because it is a restraint. RN 3 stated maybe the resident's family raised all four SRs. RN 3 stated when a resident is restrained, they may become more agitated and a higher risk for falls from trying to climb over the SRs. RN 3 stated if a resident had a fall from attempting to get over the SRs it could cause bleeding and potentially hospitalization from a concussion or internal bleeding.<br><br>During a review of the facility policy and procedure titled, Physical Restraint, last reviewed 7/25/2024, the policy indicated a physical restraint is any manual method or physical or mechanical device or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body. Upon admission, all residents shall be assessed for fall risk. Anyone with a score of eight or above shall be assessed for physical restraint use. If interventions such as lowering the bed, using pillows, and alarms did not work, a physical restraint assessment shall be completed by a licensed nurse (LN) with input from the interdisciplinary team (IDT, a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological, and spiritual needs of the patient). The IDT shall evaluate and make recommendations. The LN is responsible for obtaining an order from the attending physician which includes: the specific type of restraint, the purpose, the time, and place of application, approaches to prevent decreased functioning, and obtaining informed consent. The LN shall complete the Informed Consent Acknowledgement form.<br><br>During a review of the facility policy and procedure titled, Bed Safety and Bed Rails, last reviewed 7/25/2024, the policy indicated resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of rails is prohibited unless the criteria for use of bed rails have been met. The definition of restraint is based on the functional status of the resident and not on the device, therefor any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint. The use of SRs is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Before using SRs for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent.<br><br>During a review of the facility policy and procedure titled, Physician Orders and Telephone Orders, last reviewed 7/25/2024, the policy indicated physician's orders shall be obtained prior to the initiation of any treatment from a person lawfully authorized to prescribe for and treat human illness.<br><br>During a review of the facility policy and procedure titled, Informed Consent, last reviewed 7/25/2024, the policy indicated physician's orders related to the use of physical restraints shall not be initiated until an informed consent is obtained. A Physical Restraint is any manual method or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. This includes using side rails that keep a resident from voluntarily getting out of bed. The disclosure of material information and obtaining informed consent is the responsibility of the physician. The material information is provided to the resident or surrogate that is material to the resident's decision, concerning whether to accept or refuse any proposed treatment or procedure.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the Bed Frame 1 (BF 1) Manufacture Guidelines, undated, the guidelines indicated patient entrapment with bed SRs may result in serious injury or death. Always evaluate patient for and guard against SR entrapment in accordance with medical protocols.<br><br>43988<br><br>4. During a review of Resident 63's Admission Record, the Admission Record indicated the facility admitted the resident on 9/13/2022 and readmitted the resident on 9/20/2022 with diagnoses including but not limited to chronic respiratory failure (a long term condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and generalized muscle weakness.<br><br>During a review of Resident 63's H&P, dated 4/1/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 63's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all ADLs. The MDS indicated Resident 63 had a limb restraint.<br><br>During a review of Resident 63's Order Summary Report, dated 5/30/2023, the Order Summary Report indicated right hand mitten to decrease potential injury related to episodes of pulling on life sustaining tube (informed consent obtained by physician after explanation of risks and benefits) every shift.<br><br>During a concurrent observation and interview on 9/4/2024 at 1:50 p.m., inside Resident 63's room with CNA 6, observed Resident 63 wearing bilateral hand mittens, and the cuffs were applied too tight. CNA 6 stated verified he applied the bilateral hand mittens with CNA 7 after providing ADL care to the resident. When asked, CNA 6 attempted to insert two (2) fingers underneath the hand mitten cuff and buckle but was unable to do so.<br><br>During a concurrent observation and interview on 9/4/2024 at 2:00 p.m., inside Resident 63's room with RN 1, RN 1 verified Resident 63 had bilateral hand mittens on and were applied too tight. RN 1 stated staff can check if the mittens are too tight by inserting 2 fingerbreadths underneath the cuff and buckle. RN 1 stated she was unable to put her fingers underneath the buckle. RN 1 stated if the mittens were applied too tight, it can cause skin breakdown.<br><br>During a concurrent interview and interview on 9/4/2024 at 3;17 p.m., with the Minimum Data Set Nurse (MDSN), reviewed Resident 63's Order Summary Report. The MDSC verified the physician's order indicated an order for right hand mitten. The MDSC stated the physicians' order should have been followed to apply right hand mitten instead of applying both hand mittens because the resident was placed at risk for poor circulation, skin breakdown, and emotional distress due to inability to move the left hand freely.<br><br>During a review of the facility's P&P titled, Physical Restraints, last reviewed 7/25/2024, the P&P indicated:<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Physical restraints are any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body.<br><br>Less restrictive measures shall be attempted, and effectiveness of these measures is to be documented.<br><br>The IDT shall evaluate the outcome of all measures attempted and make recommendations accordingly.<br><br>The licensed nurse shall obtain an order from the attending physician, which is to include the specific type of restraint, purpose of the restraint, tie and place of application, approaches to prevent decreased functioning, and informed consent from resident or surrogate decision-maker.<br><br>5. During a review of Resident 73's Admission Record, the Admission Record indicated the facility admitted the resident on 11/2/2023 and readmitted in the facility on 8/13/2024 with diagnoses including but not limited to chronic respiratory failure, tracheostomy, and epilepsy.<br><br>During a review of Resident 73's H&P, dated 8/14/2024, indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 73's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition and required total assistance from staff with all ADLs. The MDS indicated Resident 73 had impairment on both upper extremities.<br><br>During a review of Resident 73's Order Summary Report dated 8/13/2024, the Order Summary Report indicated:<br><br>-Bilateral upper half side rails up when in bed for safety and protection secondary to involuntary movement by gravity due to elevated head of bed for management of tracheostomy and provision of enteral feeding (EF - a type of liquid nutrition delivered through a flexible tube that goes in through the nose or directly into the stomach) [Informed consent obtained from responsible party after explanation of risks and benefits and verified with physician].<br><br>During a review of Resident 73's fall risk assessments dated 2/23/2024, 6/11/2024, 8/13/2024, and 8/23/2024, the fall risk assessments indicated Resident 73 was a high risk for falls.<br><br>During a concurrent observation, interview, and record review on 9/3/2024 at 11:36 a.m., inside Resident 73's room with RN 2, RN 2 stated the resident is lying in bed with four side rails in raised position. RN 2 stated the physician's order for side rails was not followed because the order dated 8/13/2024, indicated to use bilateral upper half side rails while the resident is in bed. RN 2 stated using all four side rails restricts the resident's movement.<br><br>During a concurrent interview and record review on 9/4/2024 at 2:58 p.m., reviewed Resident 73's Order Summary Report with the MDSC. The MDSC stated Resident 73's physician's order indicated bilateral upper half siderails up while in bed. The MDSC stated using four siderails up while Resident 73 is in bed is considered a restraint because the resident would be unable to get out of bed, restricting the resident's movement.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled, Physical Restraints, last reviewed 7/25/2024, the P&P indicated:<br><br>Physical restraints are any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body.<br><br>Less restrictive measures shall be attempted, and effectiveness of these measures is to be documented.<br><br>The IDT shall evaluate the outcome of all measures attempted and make recommendations accordingly.<br><br>The licensed nurse shall obtain an order from the attending physician, which is to include the specific type of restraint, purpose of the restraint, tie and place of application, approaches to prevent decreased functioning, and informed consent from resident or surrogate decision-maker.<br><br>During a review of the facility's P&P titled, Bed Safety and Bed Rails, last reviewed 7/25/2024, the P&P indicated:<br><br>Bed rails are adjustable metal or rigid plastic bars that attach to the bed, they are available in a variety of types, shapes, and sizes ranging from full to on-half, one-quarter, or one-eight lengths. Some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed; bed rails include side rails and safety rails and grab bars.<br><br>The use of bed rails or side rails including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.<br><br>Before using bed rails for any reason, the staff shall inform the resident or RP about the benefits and potential hazards associated with bed rails and obtain informed consent. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418<br><br>Based on observation, interview, and record review, the facility failed to ensure residents receive an accurate assessment for one of five sampled residents (Resident 37) investigated under the physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body) care area when Resident 37's Minimum Data Set (MDS, a standardized assessment and care screening tool) did not indicate the use of bed rails (also known as side rails [SR], adjustable metal or rigid plastic bars that attach to the bed and are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths and may be positioned in various locations on the bed; upper or lower, either or both sides) or other forms of restraints were in use.<br><br>This deficient practice had the potential to result in a delay of care for the resident.<br><br>Cross-reference F604, F656, and F700.<br><br>Findings:<br><br>During a review of Resident 37's Admission Record, the admission record indicated the facility originally admitted Resident 37 on 4/12/2019 and readmitted the resident on 6/27/2022, with diagnoses including, but not limited to, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures [a sudden, uncontrolled burst of electrical activity in the brain that can cause temporary changes in a person's behavior, movements, feelings, and level of awareness]).<br><br>During a review of Resident 37's MDS, dated [DATE], the MDS indicated Resident 37 was rarely or never understood, was dependent on staff for activities of daily living such as eating, hygiene, toileting, dressing, bathing, and surface-to-surface transfers. The MDS further indicated bed rails and other types of restraints were not used.<br><br>During a review of Resident 37's History and Physical, dated 8/7/2024, the H&P indicated Resident 37 did not have the capacity to understand and make decisions.<br><br>During an observation on 9/3/2024, at 10:07 a.m., inside Resident 37's room, Resident 37 was sleeping in bed, facing towards the resident's left side, towards the wall. Resident 37's bed was placed against the wall, in the far-right corner upon entry into the room, with the head of the bed pointing towards the room window, the foot of the bed pointing toward the doorway, and the left side of the bed against the wall. Resident 37's bed had two quarter rails on the head and foot of the right side of the bed. Resident 37's bed had pillows placed along the right side, under the mattress, and elevated the right side of the bed to slightly below the top of quarter rails.<br><br>During an observation on 9/5/2024, at 2:26 p.m., inside Resident 37's room, Resident 37 was sleeping in bed. Resident 37's bed had pillows placed underneath the right side of the mattress, creating an angled incline away from Resident 37's right side.<br><br>(continued on next page) |

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| | 056159 | A. Building<br>B. Wing | 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Sherman Village Hcc | 12750 Riverside Drive<br>North Hollywood, CA 91607 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview with Restorative Nurse Aide (RNA) 2, on 9/5/2024, at 2:34 p. m., inside Resident 37's room, RNA 2 confirmed the presence of pillows underneath the right side of Resident 37's mattress and the bed rail at the right side of the head of the bed was up. RNA 2 stated Resident 37 is very active and makes attempts to jump out of the bed. RNA 2 stated Resident 37's certified nursing assistants (CNA) must have placed the pillows underneath the resident's mattress. RNA 2 further stated Resident 37's family sometimes puts the pillows under that mattress.<br><br>During an interview with Family Member (FM) 2, on 9/5/2024, at 2:53 p.m., FM 2 stated she is the family member of Resident 37 and prefers to have the pillows underneath the resident's mattress because the resident jumps out of the bed. FM 2 further stated she and the facility staff place the pillows underneath Resident 37's mattress.<br><br>During an interview with CNA 9, on 9/6/2024, at 9:07 a.m., CNA 9 stated she was assigned to Resident 37. CNA 9 stated Resident 37 attempts to jump out of his bed and pillows are placed underneath Resident 37's mattress to position his mattress at an angle so that the resident is more toward the wall of the room and to protect the resident.<br><br>During a concurrent observation and interview with the Minimum Data Set Coordinator (MDSC), on 9/6/2024, at 9:27 a.m., inside Resident 37's room, the MDSC confirmed Resident 37 had pillows placed underneath the right side of his mattress and that the pillows should not be placed there because it can be considered a restraint. The MDSC stated there have been instances where Resident 37 attempts to roll out of bed and the pillows placed under the mattress help keep him in place. The MDSC confirmed Resident 37 had quarter bed rails on the left and right side of his bed. The MDSC stated as long as there is an order for use of bed rails as an assistive device, bed rails are not considered a restraint. The MDSC reviewed Resident 37's Order Summary Report, with orders active as of 9/6/2024, and confirmed Resident 37 did not have orders to place pillows underneath the resident's mattress and orders for use of bed rails and stated because the resident does not have an order, the bed rails and pillows are considered a restraint. The MDSC reviewed Resident 37's MDS, dated [DATE], and confirmed the MDS section for restraints did not indicate Resident 37 used bed rails or other types of restraints. The MDSC further stated Resident 37 has been using bed rails since before 5/24/2024 and that the restraints should have been coded into the MDS.<br><br>During an interview with the Director of Nursing (DON), on 9/6/2024, at 2:01 p.m., the DON stated it is important to have an accurate MDS because it provides a clinical picture of the resident and the information from the MDS can be used to develop a plan of care.<br><br>During a review of the facility's policy and procedure (P&P) titled, Resident Assessment, last reviewed 7/25/2024, the P&P indicated the MDS shall be completed for each resident and sources of information to complete the MDS include review of residents' records, including hospital discharge records, communication with the resident, observations and/or assessments of the resident, communication with health providers, communications with physicians, and communications with the family. The P&P further indicated the comprehensive assessment shall be used to develop a comprehensive care plan to allow the resident to reach his or her highest practicable level of physical, mental, and psychosocial functioning. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244<br><br>Based on interview and record review, the facility failed to ensure residents who had a Preadmission Screening and Resident Review (PASARR, a federal requirement to help ensure all residents to a nursing facility are evaluated for serious mental disorder [clinically significant disturbance in an individual's cognition, emotional regulation, or behavior] and receive the services they need) Level I pre-screen that was negative and were later identified with a serious mental disorder were referred for a Level II evaluation (provides a determination of an individual's mental health needs) for one of one sampled residents (Residents 52) reviewed under the PASSAR care area and one randomly reviewed resident (Resident 42).<br><br>This deficient practice had the potential to result in residents not receiving services specified by the State that exceed the services ordinarily provided by the nursing facility that may include hiring additional staff or contractors such as qualified mental health/intellectual disability professionals.<br><br>Findings:<br><br>a. During a review of Resident 42's Admission Record, the Admission Record indicated the facility admitted the resident on 4/13/2024 with diagnoses that included encephalopathy (a change in your brain function due to injury or disease), unspecified mood disorder (a serious mental health condition marked by disruptions in emotions [severe lows called depression or highs called hypomania or mania]), traumatic brain injury (a brain injury that is caused by an outside force), anxiety, and depression.<br><br>During a review of Resident 42's Minimum Data Set (MDS - an assessment and care screening tool) dated 7/11/2024, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS indicated the resident required partial/moderate assistance from staff for toileting, dressing, personal hygiene, moving from sit to stand, transferring from the chair to bed, and toilet transfers.<br><br>During a review of Resident PASARR Level 1 Screening, dated 4/3/2024, the screening indicated the resident did not have a serious diagnosed mental disorder such as depressive disorder or mood disorder.<br><br>During a review of Resident 42's PASARR letter, dated 4/3/2024, the letter indicated the Level 1 Screening for Resident 42 is negative, and a Level II screening is not required.<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 9/4/2024 at 8:50 a.m., with the Admissions Supervisor (AS), reviewed Resident 42's PASARR Level 1 Screening, dated 4/3/2024 and Admission Record diagnoses. The AS stated prior to admission the hospital completes the PASARR Level 1 Screening and she (AS) checks to see if the resident has any psychotropic medication (medication that treats mental health behaviors). The AS stated she does not check the screening to ensure it is accurate. The AS stated Resident 42 was admitted to the facility with a diagnosis of an unspecified mood disorder, but the Level 1 Screening indicates the resident does not have a mood disorder and did not require a Level II evaluation. The AS stated the Level 1 screening was not correct. The AS stated the Minimum Data Set Coordinator (MDSC) reviews the Level 1 screening at admission and cross references the data to make any necessary correction.<br><br>During a concurrent interview and record review on 9/4/2024 at 9 a.m., with the Minimum Data Set Coordinator (MDSC), reviewed Resident 42's PASARR Level 1 Screening, dated 4/3/2024 and admitting diagnoses. The MDSC stated upon a resident's admission, she reviews the PASARR for the need for a Level II evaluation. The MDSC stated she will check the Level 1 Screening for accuracy by cross referencing with the resident's clinical documents. The MDSC stated if the Level 1 Screening is not accurate the process is to clarify the diagnosis with the doctor, interview the resident, and then update the PASSAR with the change of condition. The MDSC stated if the Level 1 Screening becomes positive then a Level 2 evaluation will need to be completed to determine the services to provide to the resident. The MDSC stated Resident 42's Level 1 Screening was not correct and needed to be corrected, but it was not done due to an oversight. The MDSC stated the potential negative affect would be that the resident was not provided the proper mental health care.<br><br>During a concurrent interview and record review on 9/5/2024 at 1:50 p.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedure regarding behavioral health. The DON stated it was important to assure the accuracy of the PASARR Level 1 Screening for mental health disorders because it facilitates the proper plan of care for the resident and the Level II evaluation would provide additional services. The DON stated Resident 42 had a mental health issue and would benefit from any additional mental health services, but the facility policy was not followed to ensure the resident received the Level II evaluation.<br><br>During a review of the facility policy and procedure titled, Behavioral Assessment, Intervention and Monitoring, last reviewed 7/25/2024, the policy indicated the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Residents will have minimal complications associated with the management of altered or impaired behavior. As part of the initial assessment, the nursing staff and attending physician will identify individuals with a history of mental health disorders and altered behaviors. All residents will receive a Level 1 PASARR screen prior to admission. If the level 1 screen indicates the individual may meet the criteria for a mental disorder or related condition, he or she will be referred to the state PASARR representative for a Level II screening process. New onset or changes in behavior that indicate newly evident or possible serious mental disorder or related disorder will be referred for a PASARR Level II evaluation.<br><br>b. During a review of Resident 52's Admission Record, the Admission Record indicated the facility admitted the resident on 11/16/2021 and readmitted the resident on 2/2/2024 with diagnoses that included unspecified mood (affective) disorder with an onset date of 6/7/2022.<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 52's MDS dated [DATE], the MDS indicated the resident usually was able to understand others and usually was able to make himself understood. The MDS indicated the resident was dependent on staff for toileting, dressing, bathing, and personal hygiene.<br><br>During a review of Resident 52's Preadmission Screening and Resident Review (PASARR) Level 1 Screening, dated 1/3/2022, the screening indicated the resident did not have a serious diagnosed mental disorder such as depressive disorder or mood disorder.<br><br>The Level 1 Screening for Resident 52 is negative, and a Level II screening is not required.<br><br>During a concurrent interview and record review on 9/4/2024 at 8:50 a.m., with the Admissions Supervisor (AS), reviewed Resident 52's PASARR Level 1 Screening, dated 1/3/2024 and Admission Record diagnoses. The AS stated prior to admission the hospital completes the PASARR Level 1 Screening and she (AS) checks to see if the resident has any psychotropic medication (medication that treats mental health behaviors). The AS stated she does not check the screening to ensure it is accurate. The AS stated Resident 52 was admitted to the facility with a diagnosis of an unspecified mood disorder, but the Level 1 Screening indicates the resident does not have a mood disorder and did not require a Level II evaluation. The AS stated the Level 1 screening was not correct. The AS stated the Minimum Data Set Coordinator (MDSC) reviews the Level 1 screening at admission and cross references the data to make any necessary correction.<br><br>During a concurrent interview and record review on 9/4/2024 at 9 a.m., the MDSC reviewed Resident 52's PASARR Level 1 Screening, dated 1/3/2022 and Admitting Diagnoses. The MDSC stated upon a resident's admission, she reviews the PASARR for the need for a Level II evaluation. The MDSC stated she will check the Level 1 Screening for accuracy by cross referencing with the resident's clinical documents. The MDSC stated if the Level 1 Screening is not accurate the process is to clarify the diagnosis with the doctor, interview the resident, and then update the PASSR with the change of condition. The MDSC stated if the Level 1 Screening becomes positive then a Level 2 evaluation will need to be completed to determine the services to provide to the resident. The MDSC stated Resident 52's Level 1 Screening was not correct because the resident was readmitted on [DATE] with new diagnosis of a mood disorder and the Level 1 screening was negative and needed to be corrected, but it was not done due to an oversight. The MDSC stated the potential negative affect would be that the resident was not provided the proper mental health care.<br><br>During a concurrent interview and record review on 9/5/2024 at 1:50 p.m., with the Director of Nursing (DON), reviewed the facility policy and procedure regarding behavioral health. The DON stated it was important to assure the accuracy of the PASARR Level 1 Screening for mental health disorders because it facilitates the proper plan of care for the resident and the Level II evaluation would provide additional services. The DON stated Resident 52 had a mental health issue and would benefit from any additional mental health services, but the facility policy was not followed to ensure the resident received the Level II evaluation.<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility policy and procedure titled, Behavioral Assessment, Intervention and Monitoring, last reviewed 7/25/2024, the policy indicated the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Residents will have minimal complications associated with the management of altered or impaired behavior. As part of the initial assessment, the nursing staff and attending physician will identify individuals with a history of mental health disorders and altered behaviors. All residents will receive a Level 1 PASARR screen prior to admission. If the level 1 screen indicates the individual may meet the criteria for a mental disorder or related condition, he or she will be referred to the state PASARR representative for a Level II screening process. New onset or changes in behavior that indicate newly evident or possible serious mental disorder or related disorder will be referred for a PASARR Level II evaluation. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418<br><br>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for two of five sampled residents (Resident 37 and 63) investigated during review of the physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body) care area when:<br><br>1. Resident 37 did not have a care plan for the use of pillows placed underneath the mattress.<br><br>2. Resident 63 did not have a care plan addressing the resident's Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities) status.<br><br>These deficient practices had the potential to result in inconsistent implementation of the care plan that may lead to a delay in care or lack of delivery of care and services for the residents.<br><br>Cross-reference F604 and F641.<br><br>Findings:<br><br>1. During a review of Resident 37's Admission Record, the admission record indicated the facility originally admitted Resident 37 on 4/12/2019 and readmitted the resident on 6/27/2022, with diagnoses including, but not limited to, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures [a sudden, uncontrolled burst of electrical activity in the brain that can cause temporary changes in a person's behavior, movements, feelings, and level of awareness]).<br><br>During a review of Resident 37's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/24/2024, the MDS indicated Resident 37 was rarely or never understood, was dependent on staff for activities of daily living such as eating, hygiene, toileting, dressing, bathing, and surface-to-surface transfers. The MDS further indicated bed rails and other types of restraints were not used.<br><br>During a review of Resident 37's History and Physical (H&P), dated 8/7/2024, the H&P indicated Resident 37 did not have the capacity to understand and make decisions.<br><br>During an observation on 9/3/2024, at 10:07 a.m., inside Resident 37's room, Resident 37 was sleeping in bed, facing towards the resident's left side, towards the wall. Resident 37's bed was placed against the wall, in the far-right corner upon entry into the room, with the head of the bed pointing towards the room window, the foot of the bed pointing toward the doorway, and the left side of the bed against the wall. Resident 37's bed had two quarter rails on the head and foot of the right side of the bed. Resident 37's bed had pillows placed along the right side, under the mattress, and elevated the right side of the bed to slightly below the top of quarter rails.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 9/5/2024, at 2:26 p.m., inside Resident 37's room, Resident 37 was sleeping in bed. Resident 37's bed had pillows placed underneath the right side of the mattress, creating an angled incline away from Resident 37's right side.<br><br>During a concurrent observation and interview with Restorative Nurse Aide (RNA) 2, on 9/5/2024, at 2:34 p. m., inside Resident 37's room, RNA 2 confirmed the presence of pillows underneath the right side of Resident 37's mattress and the bed rail at the right side of the head of the bed was up. RNA 2 stated Resident 37 is very active and makes attempts to jump out of the bed. RNA 2 stated Resident 37's certified nursing assistants (CNA) must have placed the pillows underneath the resident's mattress. RNA 2 further stated Resident 37's family sometimes puts the pillows under that mattress.<br><br>During an interview with Family Member (FM) 2, on 9/5/2024, at 2:53 p.m., FM 2 stated she is the family member of Resident 37 and prefers to have the pillows underneath the resident's mattress because the resident jumps out of the bed. FM 2 further stated she and the facility staff place the pillows underneath Resident 37's mattress.<br><br>During an interview with CNA 9, on 9/6/2024, at 9:07 a.m., CNA 9 stated she was assigned to Resident 37. CNA 9 stated Resident 37 attempts to jump out of his bed and pillows are placed underneath Resident 37's mattress to position his mattress at an angle so that the resident is more toward the wall of the room and to protect the resident.<br><br>During a concurrent observation and interview with the Minimum Data Set Coordinator (MDSC), on 9/6/2024, at 9:27 a.m., inside Resident 37's room, the MDSC confirmed Resident 37 had pillows placed underneath the right side of his mattress and that the pillows should not be placed there because it can be considered a restraint. The MDSC stated there have been instances where Resident 37 attempts to roll out of bed and the pillows placed under the mattress help keep him in place. The MDSC reviewed Resident 37's Care Plans, active as of 9/6/2024, and the MDSC confirmed Resident 37 did not have care plans related to the placement of pillows underneath the resident's mattress. The MDSC further stated Resident 37 should have a care plan to make sure there are interventions to monitor the resident, make sure the facility staff are aware of the plan, and to help guide the facility staff to provide proper care.<br><br>During an interview with the Director of Nursing (DON), on 9/6/2024, at 2:01 p.m., the DON stated the purpose and importance of care plans is to identify issues existing to the resident, to make a plan to assist the resident, and to have a goal to provide optimal care to the resident. The DON further stated care plans can change and they need to be updated to ensure that residents get the optimum care.<br><br>During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed 7/25/2024, the P&P indicated a comprehensive, person-centered care plan:<br><br>a. Includes measurable objectives and timeframes;<br><br>b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including:<br><br>1. Services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Which professional services are responsible for each element of care;<br><br>c. Includes the resident's stated goals upon admission and desired outcomes;<br><br>d. Build on the resident's strengths; and<br><br>e. Reflects currently recognized standards of practice for problem areas and conditions.<br><br>43988<br><br>2. During a review of Resident 63's Admission Record, the Admission Record indicated the facility admitted the resident on 9/13/2022 and readmitted in the facility on 9/20/2022 with diagnoses including but not limited to chronic respiratory failure (a long term condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and generalized muscle weakness.<br><br>During a review of Resident 63's H&P, dated 4/1/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 63's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 40 had impairment on both upper extremities.<br><br>During a review of Resident 63's Order Summary Report dated 3/28/2024, the Order Summary Report indicated the following:<br><br>Enhanced barrier precaution due to presence of tracheostomy and gastrostomy tube (GT - a tube inserted through the wall of the abdomen that brings nutrition directly to the stomach), don (put on) personal protective equipment (PPE - equipment worn to minimize exposure to a variety of hazards)/gown when providing direct patient care.<br><br>During a concurrent interview and review on 9/5/2024 at 4:45 p.m., with the Minimum Data Set Coordinator (MDSC), reviewed Resident 63's care plan (CP) and Order Summary Report. The MDSC stated Resident 63 had a physician's order for EBP due to tracheostomy and GT status. The MDSC stated was no CP developed to address Resident 63's EBP status.<br><br>During an interview on 9/6/2024, with the Director of Nursing (DON), the DON stated the CP on Resident 63's EBP status should have been developed to ensure staff are aware of the interventions that needed to implemented to ensure and the resident is receiving the appropriate care. The DON stated the CP prevents delay in the delivery of necessary care and services the resident needs.<br><br>(continued on next page) |

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| | 056159 | A. Building<br>B. Wing | 09/06/2024 |

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| Sherman Village Hcc | 12750 Riverside Drive<br>North Hollywood, CA 91607 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed 7/25/2024, indicated a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy indicated the comprehensive person-centered care plan is developed no more than 21 days after admission. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376<br><br>Based on interview and record review, the facility failed to provide care in accordance with professional standards for:<br><br>1. Four of ten sampled residents (Resident 24, 43, 61 and 85) investigated under insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) care area by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous ([SQ] -beneath the skin) insulin administration sites.<br><br>2. For one of one sampled resident (Resident 60) investigated during review of anticoagulant use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous ([SQ] -beneath the skin) anticoagulant injection sites.<br><br>This deficient practice increased the risk that Residents 24, 43, 61, 60 and 85 could experience adverse effects (unwanted, unintended result) from same site subcutaneous administration of insulin and enoxaparin such as bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin).<br><br>Cross Reference F760<br><br>Findings:<br><br>1.a. During a review of Resident 61's Admission Record, the record indicated the facility admitted the resident on 7/29/2024, with diagnoses including type 2 diabetes mellitus (a disease that occurs when the blood glucose, also called blood sugar, is too high), protein-calorie malnutrition (a nutritional condition that occurs when the body does not get enough protein, energy, and other essential nutrients), and diabetic chronic kidney disease (a condition that occurs when diabetes damages the kidneys over time).<br><br>During a review of Resident 61's History and Physical (H&P), dated 7/30/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 61's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/5/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others. The MDS indicated the resident had severely impaired cognitive skills (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life) and was on a high-risk drug class hypoglycemic (a class of medications that lower blood sugar levels) including insulin.<br><br>During a review of Resident 61's Order Summary Report, the report indicated an order for:<br><br>-8/31/2024 Lantus Subcutaneous Solution (Insulin Glargine, a long-acting, synthetic version of human insulin). Inject 15 unit (the biological equivalent of 34.7 micrograms of pure crystalline insulin) subcutaneously at bedtime for hyperglycemia (a condition that occurs when there is too much sugar, or glucose, in the blood).<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -8/30/2024 Novolog Injection Solution (Insulin Aspart, a rapid-acting, human insulin). Inject as per sliding scale (varies the dose of insulin based on blood sugar level): if 61-150= 0; 151-200= 3; 201-250= 5; 251-300= 8; 301-350= 10; 351-400= 12 blood sugar (BS) greater than (>) 400 give 15 unit and contact the MD, subcutaneously every 6 hours for blood sugar monitoring.<br><br>During a review of Resident 61's Location of Administration Report on the use of insulin dated 8/2024 to 9/2024, the report indicated insulin Aspart was administered on the following days and sites:<br><br>8/2/2024 at 12:22 a.m. on the Abdomen-Left Upper Quadrant (LUQ)<br><br>8/3/2024 at 12:15 a.m. on the Abdomen-LUQ<br><br>8/5/2024 at 6:04 a.m. on the Abdomen-Right Upper Quadrant (RUQ)<br><br>8/6/2024 at 5:03 a.m. on the Abdomen-RUQ<br><br>8/8/2024 at 6:05 a.m. on the Abdomen-Left Lower Quadrant (LLQ)<br><br>8/9/2024 at 5:16 a.m. on the Abdomen-LLQ<br><br>8/24/2024 at 12:11 p.m. on the Abdomen-RUQ<br><br>8/24/2024 at 6:04 p.m. on the Abdomen-RUQ<br><br>8/27/2024 at 12:01 a.m. on the Arm-left<br><br>8/27/2024 at 6:056 a.m. on the Arm-left<br><br>8/31/2024 at 5:21 p.m. on the Abdomen-RUQ<br><br>9/1/2024 at 8:11 p.m. on the Abdomen-RUQ<br><br>During a concurrent interview and record review on 9/4/2024, at 2:44 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 61's Order Summary Report and Location of Administration of insulin dated 8/2024 to 9/2024. RN 1 stated there were multiple instances where the administration sites of insulin from 8/2024 to 9/2024 were not rotated. RN 1 stated the sites for insulin administration should be rotated to prevent lipodystrophy, that can affect the absorption of the medication.<br><br>During an interview on 9/6/2024, at 2:01 p.m., with the Director of Nursing (DON), the DON stated licensed nurses should rotate the residents' insulin administration sites to prevent lipodystrophy and cutaneous amyloidosis.<br><br>During a review of the facility's recent policy and procedure titled, Insulin Administration, last reviewed on 7/25/2024, the policy and procedure indicated to select an injection site.<br><br>a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).<br><br>During a review of the facility provided Highlights of Prescribing Information on the use of Insulin Aspart injection, for subcutaneous or intravenous use, with initial U.S. approval in 2000, the highlights of prescribing information indicated to rotate injection sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis.<br><br>2. During a review of Resident 60's Admission Record, the record indicated the facility admitted the resident on 8/8/2024, with diagnoses including type 2 diabetes mellitus, long term use of insulin, and atrial fibrillation (a type of irregular heartbeat, or arrhythmia, that occurs when the heart's upper chambers beat irregularly and rapidly).<br><br>During a review of Resident 60's H&P, dated 8/8/2024, the H&P indicated the resident did not have the capacity to make decisions.<br><br>During a review of Resident 60's MDS, dated [DATE], the MDS indicated the resident usually make self-understood and understand others. The MDS indicated the resident was on a high-risk drug class anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the heart) and a hypoglycemic including insulin.<br><br>During a review of Resident 60's Order Summary Report, the report indicated an order for:<br><br>-8/27/2024 Insulin Lispro Injection Solution 100 unit/ milliliters (ml, a unit of volume) (Insulin Lispro, a rapid-acting, synthetic version of human insulin). Inject as per sliding scale: if 180-199= 2 less than 150= 0 unit; 200-249= 4; 250-299= 7; 300-349= 10; 350-400= 13 greater than 400 call MD, subcutaneously every 6 hours for diabetes mellitus type 2 (DM 2) (Rotate site).<br><br>-8/28/2024 Lovenox Injection Solution Prefilled Syringe 80 milligrams (mg, a unit of weight) /0.8 ml (enoxaparin Sodium). Inject 80 mg subcutaneously every 12 hours for deep vein thrombosis (DVT, the formation of one or more clots) prophylaxis (an attempt to prevent disease) (Rotate abdominal site). Discontinued on 8/28/2024.<br><br>During a review of Resident 60's Location of Administration Report on the use of Lovenox from 8/2024 to 9/2024, the report indicated Lovenox was administered on the following days and sites:<br><br>8/25/2024 at 5:42 a.m. on the Abdomen-LLQ<br><br>8/25/2024 at 5:39 p.m. on the Abdomen-LLQ<br><br>During a review of Resident 60's Location of Administration Report on the use of insulin from 8/2024 to 9/2024, the report indicated insukin was administered on the following days and sites:<br><br>8/17/2024 at 5:34 a.m. on the Abdomen-LUQ<br><br>8/18/2024 at 5:32 a.m. on the Abdomen-LUQ<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 9/4/2024, at 2:50 p.m., with RN 1, reviewed Resident 60's Order Summary Report and Location of Administration Report for Lovenox and insulin use from 8/2024 to 9/2024. RN 1 stated there were instances where Lovenox and insulin administration sites were not rotated from 8/2024 to 9/2024. RN 1 stated Lovenox and insulin sites of administration should be rotated to prevent bruising of the skin and lipodystrophy.<br><br>During an interview on 9/6/2024, at 2:01 p.m., with the DON, the DON stated the licensed nurses should have rotated the residents' insulin administration sites to prevent lipodystrophy and cutaneous amyloidosis. The DON also stated Lovenox administration sites should have been rotated to prevent bruising in the frequented sites of administration<br><br>During a review of facility's P&P titled, Insulin Administration, dated March 2023, the P&P indicated: To provide guidelines for the safe administration of insulin to residents with diabetes.<br><br>2.The type of insulin, .and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order.<br><br>3.Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening).<br><br>16.a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel.<br><br>16.b. injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).<br><br>During a review of manufacturer's guide for Injecting Lantus with a vial and syringe, dated 2022, the guide indicated to Change (rotate) your injection sites within the area you chose with each dose to reduce your risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred, or damaged.<br><br>During a review of manufacturer's guide for Instructions for use for Novolog, dated 1/2015, the guide indicated Injection sites should be rotated within the same region to reduce the risk of lipodystrophy. For each injection, change (rotate) your injection site within the area of skin that you use. Do not use the same injection site for each injection.<br><br>During a review of manufacturer's guide for Instructions for use for Lispro, dated 1996, the guide indicated Long-term use of insulin, , can cause lipodystrophy at the site of repeated insulin injections or infusion. Lipodystrophy includes lipohypertrophy (thickening of adipose tissue) and lipoatrophy (thinning of adipose tissue) and may affect insulin absorption. Rotate insulin injection or infusion sites within the same region to reduce the risk of lipodystrophy.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility provided Highlights of Prescribing Information for Humalog (insulin lispro injection, USP [rDNA origin]) for injection, with initial U.S. approval in 1996, the highlights of prescribing information indicated Humalog administered by subcutaneous injection should be given in the abdominal wall, thigh, upper arm, or buttocks. Injection sites should be rotated within the same region (abdomen, thigh, upper arm, or buttocks) from one injection to the next to reduce the risk of lipodystrophy.<br><br>During a review of manufacturer's guide for Instructions for use for Regular Insulin, dated 2011, the guide indicated Injection sites should be rotated within the same region.<br><br>During a review of the facility provided Highlights of Prescribing Information for Lovenox (enoxaparin sodium) injection, for subcutaneous and intravenous use, with initial U.S. approval in 1993, the highlights of prescribing information indicated to alternate injection sites between the left and right anterolateral and left and right posterolateral abdominal wall.<br><br>43455<br><br>1.b. During a review of Resident 24's Admission Record (a document containing demographic and diagnostic information,) dated 9/4/24, the Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus 2 ([DM2] - a condition where there is high blood sugar levels.)<br><br>During a review of Resident 24's Order Summary Report, dated 9/4/24, the report indicated Resident 24 was prescribed Lispro (short-acting insulin) to inject per sliding scale (insulin dosing plan whereby the amount of insulin administered depends on the resident's blood sugar level,) subcutaneous ([SQ] - under the skin) before meals and at bedtime for high blood sugar, starting 4/14/2024.<br><br>During a review of Resident 24's Medication Administration Record ([MAR] - a record of mediations administered to residents), for August and September 2024, the MARs indicated Resident 24 was prescribed insulin Lispro 20 to give per sliding scale SQ before meals and at bedtime for high blood sugar, at 6:30 AM, 11:30 AM, 4:30 PM and 9 PM.<br><br>During the same review, the MAR indicated isulin Lispro SQ was administered on the following days and sites:<br><br>8/14/24 at 9 PM on Right Upper Quadrant ([RUQ] - upper right side of abdomen)<br><br>8/15/24 at 6:30 AM on RUQ<br><br>8/19/24 at 9 PM on Left Upper Quadrant ([LUQ] - upper left side of abdomen)<br><br>8/20/24 at 6:30 AM on LUQ<br><br>9/1/24 at 4:30 PM on LUQ<br><br>9/2/24 at 4:30 PM on LUQ<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1.c. During a review of Resident 43's Admission Record dated 9/4/24, the Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including DM2.<br><br>During a review of Resident 43's Order Summary Report, dated 9/4/2024, the report indicated Resident 43 was prescribed Lantus (long-acting insulin) to inject 14 units ([un] - a measure of dosage for insulin) SQ in the morning for DM hold if blood sugar less than 100 (Rotate injection site,) starting 8/29/24, and Novolog to inject per sliding scale SQ every 6 hours for DM2 Rotate injection site, starting 8/30/24.<br><br>During a review of Resident 43's MAR for August 2024, the MAR indicated Resident 43 was prescribed Lantus 10 un SQ in the morning for DM hold if blood sugar less than 100 at 9 AM, between 7/21/2024 and 8/28/2024, Lantus 14 un SQ in the morning for DM hold if blood sugar less than 100 (Rotate injection site) at 9 AM, starting 8/29/2024, Novolog per sliding scale SQ every 6 hours for DM2 Rotate injection site at 12 AM, 6 AM, 12 PM and 6 PM, between 7/21/2024 and 8/29/2024, Novolog per sliding scale SQ every 6 hours for DM2 Rotate injection site at 12 AM, 6 AM, 12 PM and 6 PM, starting 8/30/2024.<br><br>During the same review, the MAR's indicated Lantus SQ was administered on the following days, times, and sites:<br><br>8/26/24 at 9 AM on RUQ<br><br>8/27/24 at 9 AM on RUQ<br><br>8/29/24 at 9 AM on Left Lower Quadrant ([LLQ] - lower left side of abdomen)<br><br>8/30/24 at 9 AM on LLQ<br><br>During the same review, the MAR indicated Novolog SQ was administered on the following days, times, and sites:<br><br>8/17/24 at 12 PM on RUQ<br><br>8/18/24 at 12 PM on RUQ<br><br>8/21/24 at 12 PM on LLQ<br><br>8/22/24 at 6 PM on LLQ<br><br>1.d. During a review of Resident 85's Admission Record dated 9/3/24, the Admisison Record indicated the resident was originally admitted to the facility on [DATE] with a diagnoses including DM2.<br><br>During a review of Resident 85's Order Summary Report, dated 8/31/24, the report indicated Resident 85 was prescribed Regular (short-acting insulin) insulin per sliding scale SQ two times a day for DM2 (rotate injection site,) starting 8/29/24.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 85's MAR for August 2024, the MAR indicated Resident 85 was prescribed Regular insuln per sliding scale SQ two times a day for DM2 (rotate injection site,) at 6:30 AM and 9 PM.<br><br>During the same review, the MARs indicated Regular insulin SQ was administered on the following days, times, and sites:<br><br>8/9/24 at 6:30 AM on RUQ<br><br>8/10/24 at 6:30 AM on RUQ<br><br>During a concurrent interview and record review on 9/5/24 at 2:17 PM, with Licensed Vocational Nurse (LVN) 4, LVN 4 reviewed Resident 24's MAR for August and September 2024, and Resident 43's and 85's MAR for August 2024. LVN 4 stated that Resident 43's MAR indicated to rotate injection sites for Lantus and Novolog, and Resident 85's MAR indicated to rotate injection site for Regular insulin. LVN 4 stated that for Resident 24, 43 and 85 the MARs indicated there were multiple instances where the insulin administration sites were not rotated by several licensed nurses, as expected by standard of practice, manufacturer guidelines, and MAR order instructions. LVN 4 stated the failure of the licensed nurses to rotate insulin administration sites could cause harm to Resident 24, 43 and 85 by causing skin abnormalities such as lumps in the skin or thickened skin.<br><br>During an interview on 9/5/2024, at 2:48 PM, with the Director of Nursing (DON,) the DON stated that per facility policy and manufacturer guidelines it was common knowledge for licensed nurses to rotate insulin administration sites to prevent lipodystrophy (thickened skin) to the sites that was frequently administered with insulin. The DON stated that several licensed nurses failed to rotate the insulin administration sites for Resident 24, 43 and 85 and placed the residents at risk of harm from lipodystrophy. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>44376<br><br>Based on interview and record review the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene to one of one sampled resident (Resident 60) investigated during review of activities of daily living by failing to provide Resident 60 showers every Wednesdays and Saturdays as scheduled.<br><br>This deficient practice had the potential to negatively impact Resident 60's quality of life and self-esteem due to lack of personal hygiene.<br><br>Findings:<br><br>During a review of Resident 60's Admission Record, the record indicated the facility admitted the resident on 8/8/2024, with diagnoses including dependence on respirator (unable to wean off a ventilator [a machine that helps a person breathe] and breathe independently), need for assistance with personal care, and muscle weakness.<br><br>During a review of Resident 60's History and Physical (H&P), dated 8/8/2024, the H&P indicated the resident did not have the capacity to make decisions.<br><br>During a review of Resident 60's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/15/2024, the MDS indicated the resident usually makes self-understood and understand others and was totally dependent on mobility and activities of daily living (ADLs, the basic tasks people perform to care for themselves and stay healthy). The MDS also indicated the resident was always incontinent of urine and bowel (feces).<br><br>During a review of the facility's Subacute Unit Shower Schedule, last updated on 2/17/2023, the schedule indicated Resident 60 is scheduled for a shower during Wednesdays and Thursdays between 7 a.m. to 3 p. m.<br><br>During a review of Resident 60's Care Plan (CP) titled, Resident has self-care deficits related to communication deficits, joint limitation, medical restriction, muscular weakness, pain, poor balance, poor safety awareness, unsteady gait (a manner of walking or moving on foot), and weakness, last revised on 8/29/2024, the CP indicated an intervention to shower/bathe as scheduled. Assist as needed.<br><br>During an interview on 9/3/2024, at 9:12 a.m., with Resident 60, inside Resident 60's room, Resident 60 was on a ventilator attached to a tracheostomy tube (a tube that is inserted into the windpipe through a surgically created opening in the neck) and communicated using a communication board. Resident 60 stated she has not had a shower for seven days.<br><br>During a concurrent interview and record review on 9/6/2024, at 8:56 a.m., with Certified Nursing Assistant 3 (CNA 3), reviewed Resident 60's Subacute Unit Shower Schedule and ADL- Shower/bathe Flow Sheet. CNA 3 stated the resident was provided ADL-Shower/bath on the following days:<br><br>(continued on next page) |

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| | 056159 | A. Building<br>B. Wing | 09/06/2024 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 8/24/2024 N/A evening shift (Saturday)<br><br>8/25/2024 night shift bed bath<br><br>8/25/2024 day shift bed bath<br><br>8/25/2024 evening shift bed bath<br><br>8/26/2024 day shift bed bath<br><br>8/27/2024 day shift bed bath<br><br>8/28/2024 day shift bed bath (Wednesday)<br><br>8/29/2024 day shift bed bath<br><br>8/29/2024 evening shift bed bath<br><br>8/30/2024 day shift bed bath<br><br>8/31/2024 day shift bed bath (Saturday)<br><br>8/31/2024 evening bed bath<br><br>9/1/2024 day shift bed bath<br><br>9/1/2024 evening shift bed bath<br><br>9/2/2024 day shift bed bath<br><br>9/3/2024 day shift bed bath<br><br>9/3/2024 evening shift bed bath<br><br>9/4/2024 day shift shower (Wednesday)<br><br>9/5/2024 evening shift bed bath<br><br>9/6/2024 bed bath night shift<br><br>CNA 3 stated the resident was not showered on 8/24/2024 (Saturday), 8/28/2024 (Wednesday), and 8/31/2024 (Saturday). CNA 3 stated she does not know why the resident was not provided showers on those days as indicated in the Subacute Unit Shower Schedule.<br><br>During an interview and record review on 9/6/2024, at 10:04 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 60's ADL-Shower/bathe Flow Sheet. RN 1 stated the resident did not get showered as scheduled on the following days: 8/24/2024, 8/28/2024, and 8/31/2024. RN 1 stated the resident should have been showered as scheduled to promote good hygiene and promote resident dignity.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/6/2024, at 2:01 p.m., with the Director of Nursing (DON), the DON stated the staff should follow the shower schedule, and if the resident refuses to have a shower, they (staff) need to document the refusal and offer the shower at a later time. The DON stated not providing shower to the resident violated the resident's right to a dignified existence and affected the emotional well-being of the resident.<br><br>During a review of the facility's recent policy and procedure titled, Activities of Daily Living (ADLs), Supporting, last reviewed on 7/25/2024, the policy and procedure indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:<br><br>a. hygiene (bathing, dressing, grooming, and oral care). |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>43418<br><br>Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers (also called pressure injuries and decubitus ulcers - injuries to skin and underlying tissue resulting from prolonged pressure on the skin) received treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one of three sampled residents (Resident 62) investigated under the pressure ulcer care area when Resident 62's low air loss mattress (LALM - mattress designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown) did not have a flat sheet placed over it.<br><br>This deficient practice had the potential for the resident to develop additional skin issues.<br><br>Cross-reference F584.<br><br>Findings:<br><br>During a review of Resident 62's Admission Record, the Admission Record indicated the facility originally admitted Resident 62 on 6/18/2024 with diagnoses including, but not limited to, malignant neoplasm (also known as cancer, a disease in which abnormal cells divide uncontrollably and destroy body tissue) of the prostate (a gland in the male reproductive system) and secondary malignant neoplasm of the bone.<br><br>During a review of Resident 62's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/25/2024, the MDS indicated Resident 62 had difficulty understanding and making decisions, required maximal assistance or was dependent on staff for activities of daily living such as toileting, hygiene, dressing, bathing, or showering, and surface-to-surface transfers. The MDS further indicated Resident 62 had a deep tissue injury present on admission and was using a pressure reducing device for the bed.<br><br>During a review of Resident 62's Order Summary Report, dated 7/17/2024, the Order Summary report indicated Resident 62 was ordered a low air loss mattress for wound care and management and to monitor the low air loss mattress for proper functioning.<br><br>During a review of Resident 62's Care Plan, last revised 6/25/2024, the care plan indicated Resident 62 had a sacrococcyx deep tissue injury with interventions including pressure relieving devices as needed, to use turn or lift sheets to assist with position changes, and to provide good skin care every shift.<br><br>During an observation on 9/3/2024, at 10:04 a.m., inside Resident 62's room, Resident 62 was sleeping on top of a LALM without a flat sheet placed between the resident and the mattress.<br><br>During an observation on 9/5/2024, at 2:49 p.m., inside Resident 62's room, Resident 62 was sleeping in bed covered by a blanket. Resident 62's head was resting on a pillow and the section of the mattress at the head of the bed did not have a flat sheet between the pillow and mattress.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with Certified Nursing Assistant (CNA) 8, on 9/6/2024, at 11:57 a.m., CNA 8 stated she was assigned to Resident 62 and that Resident 62 was on a LALM. CNA 8 stated she changed Resident 62's beddings earlier and placed the resident on a pad and applied an incontinence brief. CNA 8 stated residents on LALM can only have two layers and the incontinence briefs and the pad count towards the two layers. CNA 8 stated if she placed a thin sheet on the LALM, she would have to remove either the incontinence brief or pad. CNA 8 further stated Resident 62's LALM did not have a flat sheet placed over the mattress and that Resident 62's arms and legs are touching the surface material on the LALM.<br><br>During an interview with Treatment Nurse 1 (TX 1), on 9/6/2024, at 1:28 p.m., TX 1 stated that she performs the wound treatments for Resident 62. TX 1 stated Resident 62's treatments include placing the resident on a LALM. TX 1 stated when residents are placed on a LALM, the facility uses two layers, which can be an incontinence brief, pad, and/or flat sheet. TX 1 stated when she administered Resident 62's treatment, she observed the resident with a pad and an incontinence brief. TX 1 stated Resident 62's LALM should have a flat sheet covering it because an exposed mattress can potentially cause the resident's skin to stick to the mattress and be a potential cause for additional skin issues.<br><br>During an interview with the Director of Nursing (DON), on 9/6/2024, at 2:01 p.m., the DON stated a flat sheet should be placed over a LALM to provide a barrier between the resident and the LALM material to prevent the occurrence of additional skin issues for the resident.<br><br>During a review of the facility's policy and procedure (P&P) titled, Pressure-Reducing Mattresses, last reviewed 7/25/2024, the P&P indicated to place a flat sheet over the mattress, while ensuring no more than two layers of linen are between resident and pressure reducing device.<br><br>During a review of a facility provided document titled, [Pressure Reducing Mattress (PRM) 2] Operator's Manual, dated 3/15/2016, the document indicated to cover the mattress with a cotton sheet to avoid direct skin contact and improve the resident's comfort level. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>43988<br><br>Based on observation, interview, and record review the facility failed to ensure the resident's environment was free of accident hazards for seven (7) out of seven (7) sampled residents (Residents 89, 25, 446, 60, 11, 19, and 42) by failing to ensure:<br><br>1. Resident 89's sensor pad alarm (a device that triggers an audible alarm when a patient attempts to rise off the pad) in bed was properly functioning.<br><br>2. Residents 25, 446, and 60's beds were placed on the lowest position when not providing activities of daily living (ADL - basic tasks that must be accomplished every day for an individual to thrive) care.<br><br>These deficient practices placed the residents at risk for falls resulting in injuries, and even death.<br><br>3. Resident 11's oxygen concentrator (a medical device that separates nitrogen from the air so that 95% of pure oxygen can be breathed in) and enteral feeding (EF - a type of liquid nutrition delivered through a flexible tube that goes in through the nose or directly into the stomach) pole were not placed on top of the fall mat (safety features that are placed on the floor along the side of the bed in the home or next to a hospital bed).<br><br>This deficient practice had the potential to result in the pole and oxygen concentrator becoming unstable on a soft surface resulting in resident injury.<br><br>4. Resident 19's wheelchair (WC) was not left unattended on top of a floor mat (fall mat, designed to help prevent injuries by providing a soft-landing surface for residents who may accidentally fall out of bed).<br><br>5. Resident 42's bathroom flooring under the shower chair was in good repair.<br><br>(Cross reference F584)<br><br>These deficient practices had the potential to result in the resident's wheelchair and shower chair becoming unstable and toppling over resulting in injury to the residents.<br><br>Findings:<br><br>1. During a review of Resident 89's Admission Record, the Admission Record indicated the facility admitted the resident on 7/24/2024 with diagnoses including but not limited to acute respiratory failure (a condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and generalized muscle weakness.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 89's History and Physical (H&P) dated 7/25/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 89's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/30/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 89 had impairment on both upper extremities.<br><br>During a review of Resident 89's fall risk assessments dated 7/25/2024, the fall risk assessment indicated the resident was a high risk for falls.<br><br>During a review of Resident 89's care plan (CP), the CP on use of sensor pad alarm due to spontaneous activity or behavior of trying to get up unassisted last revised 8/25/2024 with target date 11/19/2024, indicated the following interventions but not limited to:<br><br>Apply sensor pad alarm as ordered.<br><br>Monitor the alarm for good working condition and proper placement as needed.<br><br>Staff will respond promptly to resident once alarm is activated.<br><br>During a review of Resident 89's Order Summary Report, the Order Summary Report indicated a physician's order dated 8/21/2024 for the following:<br><br>- Apply pad alarm in bed as nursing intervention to alert staff for unassisted transfer. Charge nurse to check proper placement and function every shift.<br><br>During a concurrent observation and interview on 9/3/2024 at 9:48 a.m., inside Resident 89's room with Registered Nurse 2 (RN 2), observed resident lying in bed with a pad alarm attached to the left upper siderail with a strap. Observed the resident moving spontaneously, however, the pad alarm did not go off. RN 2 stated Resident 89 has a sensor pad alarm underneath the fitted sheets due to spontaneous movement of trying to get up unassisted and the sensor pad will make an audible alarm sound when the resident moves. RN 2 verified the sensor pad was slightly folded and the alarm did not function when Resident 89 moved and turned to the side. RN 2 stated the alarm will usually have a blinking light to ensure it was functioning properly. RN 2 disconnected the sensor/cord from the plug and checked the battery compartment. Observed the alarm box with blinking light and making an audible sound when the resident moved. RN 2 stated the charge nurses and Certified Nursing Assistants (CNAs) are responsible in ensuring the alarms are functioning properly every shift. RN 2 stated alarms should be functioning properly to ensure resident safety and prevent injuries resulting from falls.<br><br>During an interview on 9/6/2024 at 3:05 p.m., with the Director of Nursing (DON), the DON stated the charge nurses and CNAs are responsible in checking the bed alarms' functionality every shift and the monitoring is documented on the Medication Administration Record (MAR). The DON stated the sensor pad alarm should be checked for functionality every shift to prevent the resident from getting out of bed unassisted, which may lead to falls or injuries.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's policy and procedure (P&P) titled, Personal Alarm, last reviewed 7/25/2024, the P&P indicated:<br><br>- The facility will use a sensor pad that sounds an audible alarm when the sensor detects a patient rising out of the bed/wheelchair reminding the resident to return to a safe position while alerting staff to a potential fall.<br><br>- Check the alarm every day for proper functioning.<br><br>- Alarm sound will automatically turn off when resident is placed back to his/her bed or chair.<br><br>- Nursing will monitor proper functioning and positioning of personal alarm.<br><br>During a review of the facility provided manufacturer's guideline for Medical Equipment 1 (ME 1), undated, the guideline indicated the following:<br><br>- Ensure all parts of the system are operational before leaving a patient unattended.<br><br>- Make sure alarm is On and in monitoring mode (light flashing green).<br><br>- Check that the plug on the sensor is not damaged and securely connected to the alarm.<br><br>- Make sure the sensor lays flat on surface, directly under the patient's weight.<br><br>- Test alarm and nurse call functions by activating alarm and removing pressure from the sensor pad before leaving patient unattended.<br><br>- To reduce the risk of serious injury or death, test the alarm and sensor for proper operation prior to putting in service with a patient, and each time before leaving the patient unattended.<br><br>2.a. During a review of Resident 25's Admission Record, the Admission Record indicated the facility admitted the resident on 11/25/2019 and readmitted the resident on 4/16/2024 with diagnoses including but not limited to chronic respiratory failure (a long term condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and functional quadriplegia (a condition that refers to the complete inability to move due to severe disability).<br><br>During a review of Resident 25's History and Physical (H&P) dated 4/16/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 25's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/9/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 25 had impairment on both upper extremities.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 25's fall risk assessments dated 1/7/2024, 4/11/2024, 4/17/2024, and 7/9/2024, the fall risk assessments indicated the resident was a high risk for falls.<br><br>During a review of Resident 25's care plan (CP), the CP indicated the following:<br><br>Resident is at risk for falls/injury related to but not limited to immobility with involuntary movement by head of bed elevation, and tracheostomy management last revised 2/3/2024 with a target date 10/7/2024, indicated to provide resident with a safe and clutter-free environment as one of the interventions.<br><br>Resident is at risk for falls and injuries, on bilateral upper half siderails up (a type of safety device that can be attached to a bed frame to help prevent falls and provide support for getting in and out of bed) last revised 2/3/2024 with target date 107/2024, indicated to provide safety measures to reduce risk of falls/prevent injuries.<br><br>During a concurrent observation and interview on 9/3/2024 at 10:14 a.m., inside Resident 25's room with Certified Nursing Assistant 3 (CNA 3), CNA 3 verified Resident 25's bed was raised to a high position. CNA 3 stated all resident beds should be kept at its lowest position at all times for their safety, due to the risk of falls when they cough. CNA 3 measured Resident 25's height of bed as 27 inches from the floor. CNA 3 lowered down the height of the bed by 6 inches. CNA 3 stated there is still room to lower down the height of bed.<br><br>During a concurrent interview and record review on 9/5/2025 at 2:50 p.m., with Registered Nurse 2 (RN 2), reviewed Resident 25's CP. RN 2 stated the CP indicated Resident 25 was a high risk for falls due to involuntary movements such as coughing episodes due to presence of tracheostomy. RN 2 stated Resident 25's bed should always be kept at its lowest position when staff are not providing ADL care, to prevent injuries resulting from falls.<br><br>During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, last reviewed 7/25/2024, the P&P indicated the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The P&P indicated environmental risk factors that contribute to risk of falls include but not limited to incorrect bed height or width.<br><br>During a review of the facility's P&P titled, Accident/Incident Prevention, last reviewed 7/25/2024, the P&P indicated the facility strives to prevent accidents by providing an environment that is free from accident hazards, identification of each resident at risk for accidents/incidents and the provision of adequate care plans with procedures to prevent accidents.<br><br>2.b. During a review of Resident 445's Admission Record, the Admission Record indicated the facility admitted the resident on 8/30/2024 with diagnoses including but not limited to tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), gastrostomy (G-tube - a surgical procedure used to insert a tube through the abdomen and into the stomach), and hemiplegia (refers to paralysis that affects only one side of the body and hemiparesis (refers to weakness that affects only one side of the body following cerebrovascular disease(a term for all disorders that affect blood flow to the brain in which an area of the brain is temporarily or permanently affected by ischemia [a term for blood flow restriction] or bleeding affecting left non-dominant side.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 445's History and Physical (H&P) dated 8/31/2024, indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 445's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 9/6/2024, the MDS indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).<br><br>During a review of Resident 445's fall risk assessment 8/31/2024, the fall risk assessments indicated the resident was a high risk for falls.<br><br>During a concurrent observation and interview on 9/3/2024 at 10:57 a.m., inside Resident 445's room with Licensed Vocational nurse 1 (LVN 1), LVN 1 verified Resident 445's bed was raised to a high position. LVN 1 stated Resident 445's bed be kept at its lowest position because the resident is at risk for falls due to involuntary movements.<br><br>During a concurrent observation and interview on 9/3/2024 at 11:00 a.m., with Respiratory Therapist 1 (RT 1), RT 1 stated Resident 445's bed was raised to a high position and stated it (the bed) should be at its lowest position to prevent falls and injuries. RT 1 measured Resident 445's height of bed as 32 inches from the floor. RT 1 adjusted the height of bed and was able to lower down the height by at least 12 inches. RT 1 stated there was room to lower down the height of bed.<br><br>During a concurrent interview and record review on 9/5/2025 at 2:50 p.m., with Registered Nurse 2 (RN 2), reviewed Resident 445's physician's orders and care plan (CP). RN 2 stated Resident 445 had a physician's order for low bed bilateral upper half side rails up to decrease potential injury. RN 2 stated Resident 445 had a baseline (CP) dated 8/30/2024, for safety/risk for falls related to seizure (an abnormal electrical activity in the brain that temporarily affects consciousness, muscle control and behavior. The CP indicated an intervention to use low bed bilateral upper half side rails up to decrease potential injury. RN 2 stated Resident 445's bed should always be at its lowest position when staff are not providing ADL care to prevent injuries resulting from falls.<br><br>During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, last reviewed 7/25/2024, the P&P indicated the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The P&P indicated environmental risk factors that contribute to risk of falls include but not limited to incorrect bed height or width.<br><br>During a review of the facility's P&P titled, Accident/Incident Prevention, last reviewed 7/25/2024, the P&P indicated the facility strives to prevent accidents by providing an environment that is free from accident hazards, identification of each resident at risk for accidents/incidents and the provision of adequate care plans with procedures to prevent accidents.<br><br>During a review of the facility provided user manual for Bed Frame 2 (BF 2), undated, the manual indicated the bed works within a height range of 150 millimeters (mm - a unit of measurement) or 6 inches (in- a unit of measurement) low height to a maximum height of 680 mm or 26 in. The manual indicated it is recommended that the bed be positioned at its lowest height when unattended by caregivers to minimize the risk of patient injury from falls when getting in and out of the bed.<br><br>(continued on next page) |

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| | 056159 | A. Building<br>B. Wing | 09/06/2024 |

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| Sherman Village Hcc | 12750 Riverside Drive<br>North Hollywood, CA 91607 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 44376<br><br>2c. During a review of Resident 60's Admission Record, the record indicated the facility admitted the resident on 8/8/2024, with diagnoses including difficulty walking, muscle weakness, and fracture of left ilium and pubis (a break in one or more of the bones in the pelvis, including the ilium, pubis, ischium, sacrum, or coccyx).<br><br>During a review of Resident 60's History and Physical (H&P), dated 8/8/2024, the H&P indicated the resident did not have the capacity to make decisions.<br><br>During a review of Resident 60's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/15/2024, the MDS indicated the resident usually had the ability to make self-understood and understand others and was totally dependent on mobility and activities of daily living (ADLs, the basic tasks people perform to care for themselves and stay healthy).<br><br>During a review of Resident 60's Fall Risk Assessment, dated 8/9/2024, the assessment indicated the resident was high risk for falls.<br><br>During a review of Resident 60's Care Plan titled, Resident is at risk for falls/injury related to difficulty walking, fracture, generalized weakness, impaired cognition (a person's difficulty with thinking, learning, remembering, or making decisions), poor body balance/control, and poor safety awareness/judgment, last revised on 8/29/2024, the care plan indicated an intervention to provide resident with a safe environment and clutter-free environment.<br><br>During a concurrent observation and interview on 9/3/2024, at 9:23 a.m., with Certified Nursing Assistant 4 (CNA 4), inside Resident 60's room, observed the resident's bed raised at a high position and no care was being provided to the resident at the time of the observation. CNA 4 used a measuring tape to measure the height of the bed. CNA 4 stated the bed was thirty-three inches from the floor and stated it was too high. CNA 4 tried to lower the bed down, however, the bed controls were not working. CNA 4 stated he will call the maintenance staff to fix the bed. CNA 4 stated the bed should be at its lowest position when not providing care to the resident prevent falls with injuries.<br><br>During an interview on 9/6/2024, at 2:01 p.m., with the Director of Nursing (DON), the DON stated staff should place the bed at its lowest position when not providing care to the resident to reduce the risk of the resident sustaining an injury from a fall. The DON stated the higher the bed of the resident, the greater the risk of the resident sustaining injuries such as fractures or even death.<br><br>During a review of the facility provided USER MANUAL Bed Frame 2 (BF 2), undated, the user manual indicated The bed works within a height range of 150 millimeters (mm, a unit of length) low height to a maximum height of 680 mm. It is recommended that the bed be positioned at its lowest height when unattended by caregivers to minimize the risk of patient injury from falls when getting in and out of the bed.<br><br>During a review of the facility's recent policy and procedure titled, Fall and Fall Risk, Managing, last reviewed on 7/25/2024, the policy and procedure indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Environmental factors that contribute to the risk of falls include:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | c. incorrect bed height or width.<br><br>During a review of the facility's recent policy and procedure titled, Safety and Supervision of Residents, last reviewed on 7/25/2024, the policy and procedure indicated safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting process; QAPI reviews of safety and incident/accident data; and a facility-wide commitment safety at all levels of the organization.<br><br>3. During a review of Resident 11's Admission Record, the Admission Record indicated the facility admitted the resident on 8/20/2016 and readmitted the resident on 3/3/2021 with diagnoses including but not limited to respiratory failure (a condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and gastrostomy (G-tube -a surgical procedure used to insert a tube through the abdomen and into the stomach).<br><br>During a review of Resident 11's History and Physical (H&P) dated 6/13/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 11's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/28/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 11 had impairment on both upper extremities.<br><br>During a review of Resident 11's fall risk assessments 5/31/2024, and 9/5/2024, the fall risk assessments indicated the resident was a high risk for falls.<br><br>During a review of Resident 11's care plan (CP) on the resident receiving oxygen therapy due to respiratory failure last revised 8/20/2024 with target date 11/20/2024, the CP indicated to observe for safety when using oxygen as one of the interventions.<br><br>During a concurrent observation an interview on 9/3/2024 at 12;22 p.m., inside Resident 11's room with Certified Nursing Assistant 7 (CNA 7), observed the resident's EF pole and oxygen concentrator were partially placed on top of the floor mat. CNA 7 stated the oxygen concentrator and EF pole are not stable and there is a risk of it fall over Resident 11 and cause injury to the resident.<br><br>During a concurrent observation and interview on 9/5/2024 at 2:00 p.m., inside Resident 11's room with Registered Nurse 2 (RN 2) and Respiratory Therapist 2 (RT 2), RN 2 and RT 2 verified the oxygen concentrator and EF pole were partially placed on top of the floor mat and were not stable. RN 2 and RT 2 stated no equipment should be placed on top of the floor mat at all times. RN 2 stated the EF pole had the potential to fall over the resident and injure the resident. RT 2 stated the oxygen concentrator had the potential to fall over and pull the tubing that was connected to the resident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 9/6/2024 at 3:11 p.m., the Director of Nursing (DON), the DON stated floor mats are used to protect residents from potential injury due to fall or involuntary movements. The DON stated placing heavy equipment on top of the floor mat can cause dent and affect its integrity. The DON stated Resident 11's bed should have been moved to make space for the EF pole and the oxygen concentrator. The DON stated the EF pole and oxygen concentrator should be on a stable floor surface to ensure equipment does not fall over and cause injury to the resident.<br><br>During a review of the facility's policy and procedure (P&P) titled, Accident/Incident Prevention, last reviewed 7/25/2024, the P&P indicated the facility strives to prevent accidents by providing an environment that is free from accident hazards, identification of each resident at risk for accidents/incidents and the provision of adequate care plans with procedures to prevent accidents.<br><br>During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, last reviewed 7/25/2024, the policy indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision an assistance to prevent accidents are facility wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting process. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents.<br><br>During a review of the facility provided manufacturer's guideline for Medical Equipment 2 (ME 2) last reviewed 7/25/2024, the policy indicated FM 1 is a low-profile fall mat designed with patient safety in mind.<br><br>44244<br><br>4. During a review of Resident 19's Admission Record, the Admission Record indicated the facility admitted the resident on 8/9/2024 with diagnoses that included necrosis (death of body tissue) of right femur (the thigh bone), disorder of bone density (measure of minerals in bone that determines the strength of the bone) and structure, difficulty walking, muscle weakness, mild cognitive impairment (early stage of memory loss) and need for assistance with personal care.<br><br>During a review of Resident 19's Minimum Data Set (MDS - an assessment and care screening tool) dated 8/16/2024, the MDS indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS indicated the resident required substantial/maximal assistance from staff for toileting, bathing, and dressing; and required partial/moderate assistance from staff for personal hygiene, oral hygiene, moving from sit to stand, and transferring from the chair to bed.<br><br>During a review of Resident 19's Physician Orders Summary Report, the report indicated orders for the following:<br><br>- Low bed with floor mat to decrease potential for injury, dated 8/9/2024.<br><br>During a review of Resident 19's Care Plan (CP) titled, Resident is at risk for falls/injury related to gen. (generalized) weakness, impaired cognition, osteoporosis (decreased thickness of bone tissue), poor body balance/control, poor safety awareness/judgement, initiated 8/30/2024, the CP indicated to provide the resident with a safe environment.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 19's CP titled, Resident has self-care deficit, initiated 8/30/2024, the CP indicated to provide a safe environment.<br><br>During an observation and interview on 9/3/2024 at 10:15 a.m., Resident 19 sat in a WC on the left side of the bed, no staff were present in the room. Observed the front and back wheels of the left side of the WC on top of the padded fall mat. Observed the WC was not placed on a hard, level surface. Resident 19 stated she had been sitting next to the bed for about a half an hour after returning from physical therapy. Resident 19 stated she needed assistance to move in the WC. Resident 19 stated she had asked the staff to move the fall mat, but they insist that it remained there.<br><br>During a concurrent observation and interview on 9/3/2024 at 10:20 a.m., Certified Nursing Assistant 5 (CNA 5) entered Resident 19's room. CNA 5 stated two of Resident 19's WC wheels were on top of the fall mat and the wheels should not be on the fall mat. CNA 5 stated Resident 19 had returned from rehabilitation (rehab, physical therapy), and the rehab staff did not notify him the resident was back. CNA 5 stated he did not place Resident 19's WC on top of the fall mat.<br><br>During a concurrent interview and record review on 9/5/2024 at 1:50 p.m., with the Director of Nursing (DON), reviewed the facility policy and procedure regarding accident prevention. The DON stated the facility uses floor mats while the resident is in the bed to help prevent injury from falls. The DON stated when the resident is in the WC next to the bed, the floor mat should not be under the wheels of the WC. The DON stated if any wheels of the WC were on top of the floor mat, there was a potential that the WC could become unsteady resulting in an accident like a fall.<br><br>During a review of the facility policy and procedure titled, Accident/Incident Prevention last reviewed 7/25/2024, the policy indicated the facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control.<br><br>During a review of the facility policy and procedure titled, Safety and Supervision of Residents, last reviewed 7/25/2024, the policy indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision an assistance to prevent accidents are facility wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting process. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents.<br><br>During a review of the Floor Mat 1 (FM 1) Manufacturer's Guidelines last reviewed 7/25/2024, the policy indicated FM 1 is a low-profile fall mat designed with patient safety in mind.<br><br>5. During a review of Resident 42's Admission Record, the Admission Record indicated the facility admitted the resident on 4/13/2024 with diagnoses that included encephalopathy (a change in the brain function due to injury or disease), unspecified mood disorder (mental health condition marked by disruptions in emotions [severe lows called depression or highs called hypomania or mania]), difficulty walking, muscle weakness, acquired absence of the right leg below the knee, and traumatic brain injury (a brain injury that is caused by an outside force).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 42's Minimum Data Set (MDS - an assessment and care screening tool) dated 7/11/2024, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS indicated the resident required partial/moderate assistance from staff for toileting, dressing, personal hygiene, moving from sit to stand, transferring from the chair to bed, and toilet transfers.<br><br>During a review of Resident 42's Care Plan (CP) titled, Resident is at risk for falls/injury related to difficulty walking, gen. (generalized) weakness, poor body balance / control, initiated 5/24/2024, the CP indicated to provide the resident with a safe environment.<br><br>During a review of Resident 42's CP titled, Resident claimed he bumped his right shoulder against the bathroom wall, initiated 8/22/2024, the CP indicated a goal to minimize the risk of injury to the resident.<br><br>During a concurrent observation and interview on 9/3/2024 at 9 a.m., Resident 42 sat in his wheelchair and stated he has an amputation on his right leg and uses a shower chair placed over the toilet because it is easier for him to make transfers and to use the toilet. Resident 42 stated he hit his back when the shower chair had become unstable during a transfer. Resident 42 stated there was a broken piece of flooring under the wheel of the shower chair. Observed in Resident 42's restroom, a blue shower chair with the back wheel on top of a broken piece of laminate flooring.<br><br>During a concurrent interview and observation on 9/3/2024 at 9:15 a.m., Licensed Vocational Nurse 3 (LVN 3) entered Resident 42's restroom and stated the laminate flooring under the wheel of the shower chair is broken.<br><br>During an observation on 9/4/2024 at 12:02 p.m., observed Resident 42's restroom with the shower chair back wheel on top of a broken piece of laminate flooring.<br><br>During an interview on 9/4/2024 at 12:03 p.m., LVN 3 stated he reported Resident 42's broken piece of laminate flooring to the Maintenance Supervisor (MS) on 9/3/2024.<br><br>During a concurrent interview and observation on 9/4/2024 at 12:06 p.m., the MS entered Resident 42's restroom and stated the laminate flooring was broken and was probably not safe for Resident 42's shower chair to be placed on top of it. The MS stated nobody had reported the flooring issue to him on 9/3/2024.<br><br>During a concurrent interview and record review on 9/5/2024 at 1:50 p.m., with the Director of Nursing (DON), the DON reviewed the facility policy regarding building maintenance. The DON stated it was not safe for Resident 42's shower chair to be placed over the broken flooring because it could cause the shower chair to become unstable resulting in injury to the resident. The DON stated the broken flooring should have been reported to maintenance to be repaired, but it was not. The DON stated the facility's policy was not followed because the flooring was not assessed for safety in a timely manner.<br><br>During a review of the facility policy and procedure regarding cleaning of the facility, last reviewed 7/25/2024, the policy indicated in order to ensure the health and safety of residents, staff and visitors, it is critical that the facility be kept clean, sanitary, and in good repair at all times. <br [TRUNCATED] |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376<br><br>Based on observation, interview, and record review, the facility failed to ensure the staff providing care and services to the resident who has a feeding tube (are soft plastic tubes through which liquid nutrition travels through the gastrointestinal tract [the series of organs that food and liquids pass through as they are digested, absorbed, and leave the body as feces]) are aware of, competent in, and utilize facility protocols regarding feeding tube nutrition and care for three of six sampled residents (Residents 84, 28, 33, 35 and 60) investigated during review of tube feeding by failing to:<br><br>1. Label Residents 84 and 60's water flush bag (a bag for holding water) with the resident's name, the infusion rate of water flush, and the start and date time.<br><br>2. Label Resident 28's EF bottle with the start date and time<br><br>3. Label Resident's 33 and 35's EF bottles and water flush bags with the infusion rate ordered by the physician.<br><br>These deficient practices had the potential to result in altered nutritional status that can lead to complications such as gastritis (a condition that occurs when the stomach lining becomes inflamed, swollen, and red) from ingesting expired formula and water flush.<br><br>4. Ensure Licensed Vocational Nurse 3 (LVN 3) checked for placement of the gastrostomy tube (G-tube or GT, a tube placed directly into the stomach to give direct access for supplemental feeding, hydration, or medicine) prior to starting the EF.<br><br>This deficient practice had the potential to place Residents 80 at risk for complications of EF including peritonitis (when the thin layer of tissue inside the abdomen becomes inflamed), sepsis (a serious condition in which the body responds improperly to an infection), or death.<br><br>Findings:<br><br>1a. During a review of Resident 84's Admission Record, the record indicated the facility admitted resident on [DATE], with diagnoses including gastrostomy (a surgical procedure used to insert a tube, often referred to as g-tube, through the abdomen and into the stomach), tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow air to fill the lungs), and on respirator (a mask or device worn over the mouth and nose to protect the respiratory system by filtering out dangerous substances from inhaled air) status.<br><br>During a review of Resident 84's History and Physical (H&P), dated [DATE], the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 84's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognitive skills (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated the resident was totally dependent on eating and had a feeding tube.<br><br>During a review of Resident 84's Order Summary Report, the report indicated an order for:<br><br>-[DATE] Enteral Feed (a method of supplying nutrition directly into the gastrointestinal tract) Order. Change open bag system and g-tube feeding (GTF) every (q) night shift.<br><br>-[DATE] Enteral Feed Order every 24 hours change hydration bag.<br><br>-[DATE] Enteral Feed Order every shift. Flush enteral tube with 60 cubic centimeters (cc, a unit of volume) of water q 1 hour for 20 hours to provide 1200 cc per day.<br><br>During a concurrent observation and interview on [DATE], at 9:20 a.m., with Licensed Vocational Nurse 2 (LVN 2), inside Resident 84's room, observed Resident 84's water flush bag without a label indicating the name of the resident, the start date and time, and the rate of the water flush. LVN 2 stated the resident's water flush bag should have indicated the name of the resident, the start date and time, and the rate of the flush to ensure resident safety and ensure hydration is provided as ordered.<br><br>During an interview on [DATE], at 2:01 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses should have label the water flush bag with the name of the resident, the start date and time and the rate of the flush to ensure the resident was getting the right hydration and the water flush bag is not expired.<br><br>During a review of the facility's recent policy and procedure titled, Supplemental Water Via enteral Pump, last reviewed on [DATE], the policy and procedure indicated open system bag will be changed every 24 hours. Label bag and tubing with date and time.<br><br>1b. During a review of Resident 60's Admission Record, the record indicated the facility admitted the resident on [DATE], with diagnoses including gastrostomy, dysphagia (difficulty swallowing), and gastro-esophageal reflux disease (GERD, is a condition that occurs when stomach contents flow backward into the esophagus).<br><br>During a review of Resident 60's H&P, dated [DATE], the H&P indicated the resident did not have the capacity to make decisions.<br><br>During a review of Resident 60's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and understand others and was totally dependent on mobility and activities of daily living (ADLs, the basic tasks people perform to care for themselves and stay healthy). The MDS indicated the resident was on a feeding tube.<br><br>During a review of Resident 60's Order Summary Report, dated [DATE], the report indicated an order for enteral feed order every day shift change hydration bag.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on [DATE], at 9:32 a.m., with LVN 2, inside Resident 60's room, observed Resident 60's water flush bag without a label indicating the name of the resident, the start date and time, and the rate of the water flush. LVN 2 stated the resident's water flush bag should have indicated the name of the resident, the start date and time, and the rate of the flush to ensure resident safety and ensure hydration is provided as ordered.<br><br>During an interview on [DATE], at 2:01 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses should have label the water flush bag with the name of the resident, the start date and time and the rate of the flush to ensure the resident was getting the right hydration and the water flush bag is not expired.<br><br>During a review of the facility's recent policy and procedure titled, Supplemental Water Via enteral Pump, last reviewed on [DATE], the policy and procedure indicated open system bag will be changed every 24 hours. Label bag and tubing with date and time.<br><br>2.During a review of Resident 28's Admission Record, the record indicated the facility admitted the resident on [DATE] and readmitted the resident on [DATE], with diagnoses including protein-calorie malnutrition (a nutritional condition that occurs when the body does not get enough protein, energy, and other essential nutrients), gastrostomy, and gastritis.<br><br>During a review of Resident 28's H&P, dated [DATE], the H&P indicated the resident was awake, not alert, and oriented, not responding to yes/no questions appropriately, moving all extremities, reduced power and strength, poor coordination, and unable to ambulate. The H&P also indicated the decision maker was the family.<br><br>During a review of Resident 28's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognitive skills. The MDS also indicated the resident was dependent on eating and had a feeding tube.<br><br>During a review of Resident 28's Order Summary Report, the report indicated an order for:<br><br>-[DATE] Enteral Feed Order. Jevity 1.2 at 65 cc per hour for 20 hours via pump to provide 1300 cc/1560 kilocalories (kcal, the amount of heat required to raise one kilogram of water 1 degree centigrade) per day.<br><br>-[DATE] Enteral Feed Order every shift. Change spike set and pump tubing when hanging a new formula bag.<br><br>During a concurrent observation and interview on [DATE], at 10:02 a.m., with LVN 2, inside Resident 28's room, observed Resident 28's Jevity 1.2 feeding bottle without the start date and time. LVN 2 stated the staff should have labeled the feeding bottle the start date and time to ensure the formula was not spoiled. LVN 2 stated infusing spoiled formula can cause diarrhea and gastritis to residents.<br><br>(continued on next page) |

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| | 056159 | A. Building<br>B. Wing | 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Sherman Village Hcc | 12750 Riverside Drive<br>North Hollywood, CA 91607 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE], at 2:01 p.m., with the DON, the DON stated the staff should have labeled the feeding bottle with the resident's name and the start date and time to ensure the resident was getting the appropriate nutrition as ordered by the physician. The DON stated not labeling the feeding bottle with the start date and time placed the resident at risk for ingesting spoiled formula that can cause gastric issues to the resident.<br><br>During a review of the facility's recent policy and procedure titled, Enteral Tube Feeding via Gravity Bag, last reviewed on [DATE], the policy and procedure indicated on the formula label document initials, date, and time the formula was hung/administered, and initial that the label was checked against the order.<br><br>43988<br><br>3a. During a review of Resident 33's Admission Record, the Admission Record indicated the facility admitted the resident on [DATE] and readmitted in the facility on [DATE] with diagnoses including but not limited to chronic respiratory failure (a long term condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and gastrostomy (G-tube - a surgical procedure used to insert a tube through the abdomen and into the stomach).<br><br>During a review of Resident 33's History and Physical (H&P) dated [DATE], the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 33's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 33 was on feeding tube.<br><br>During a review of Resident 33's Order Summary Report indicated:<br><br>[DATE]: Enteral feed order every shift. Flush enteral tube with 45 milliliters (ml - a unit of measurement) of water every one (1) hour for 20 hours to provide 900 ml per day.<br><br>[DATE]: Enteral feed order every shift: Glucerna 1.2 (a nutritional supplement specifically designed for individuals who have increased nutritional needs or require specialized diets due to certain medical conditions, such as diabetes [a condition that occurs when the blood sugar is too high] kilocalories (refers to the amount of energy in what people eat and drink) at 50 ml per hour (ml/hr) for 20 hours via pump to provide 1000 ml per 1200 kcal per day.<br><br>During a review of Resident 33's care plan (CP) on risk for but not limited to dehydration (a condition that occurs when the body does not have enough water and other fluids to carry out its normal functions), weight fluctuation, and nausea and vomiting last revised [DATE] with target date [DATE], the CP indicated an intervention to administer EF and flush G-tube with water as ordered.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on [DATE] at 9:32 a.m., inside Resident 33's room, observed resident lying in bed with the EF bottle and water flush bag hanging on the pole at the resident's bedside. The EF bottle and water flush bag tubing was connected to the resident's G-tube and was delivering the EF via pump with infusion rate at 50 ml/hr and the water flush at 45 ml/hr. The EF bottle and water flush bag did not indicate the rate of infusion.<br><br>During a concurrent observation and interview on [DATE] at 10:40 a.m., inside Resident 33's room with Registered Nurse 2 (RN 2), RN 2 stated the label on Resident 33's EF bottle and water flush bag did not indicate the rate of infusion. RN 2 stated all EF bottle and water flush bag labels should indicate the resident's name, the start date and time, and the infusion rate to ensure the resident was getting the correct amount of EF and water required to meet their needs.<br><br>During an interview on [DATE] at 3:00 p.m., with the Director of Nursing (DON), the DON stated all EF bottles and water flush bags are to be changed every 12 p.m. per facility practice. The DON stated prior to starting a new EF bottle and water flush bag, the licensed nurse should check the physician's order for accuracy and ensure the label indicated the resident's name, room number, the start date and time, and the infusion rate to ensure the resident was getting the correct amount of nutrition and hydration needed.<br><br>During a review of the facility's policy and procedure (P&P) titled, Enteral Tube Feeding via Gravity Bag, last reviewed on [DATE], the P&P indicated a purpose to provide nourishment to the resident who is unable to obtain nourishment orally. The P&P indicated to check the enteral nutrition label against the order before administration. The P&P indicated, on the formula label document initials, date, and time the formula was hung/administered, rate of administration (ml/hr), and initial that the label was checked against the order.<br><br>During a review of the facility's P&P titled, Supplemental Water Via Enteral Pump, last reviewed on [DATE], indicated that supplemental water will be supplied via enteral pump as ordered by the physician to ensure adequate hydration and assist in the prevention of but not limited to dehydration, G-tube clogging, and need to provide bolus flushing. The P&P indicated that the open system bag will be changed every 24 hours and should label the bag with the date and time, and rate of administration.<br><br>3b. During a review of Resident 55's Admission Record, the Admission Record indicated the facility admitted the resident on [DATE] and readmitted in the facility on [DATE] with diagnoses including but not limited to chronic respiratory failure (a long term condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and gastrostomy (G-tube - a surgical procedure used to insert a tube through the abdomen and into the stomach).<br><br>During a review of Resident 55's History and Physical (H&P) dated [DATE], the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 55's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 55 was on feeding tube.<br><br>During a review of Resident 55's Order Summary Report indicated:<br><br>[DATE]: Enteral feed order every shift. Flush enteral tube with 60 milliliters (ml - a unit of measurement) of water every one (1) hour for 20 hours to provide 1200 ml of water.<br><br>[DATE]: Enteral feed order every shift: Glucerna 1.2 (a nutritional supplement specifically designed for individuals who have increased nutritional needs or require specialized diets due to certain medical conditions, such as diabetes [a condition that occurs when the blood sugar is too high] kilocalories (refers to the amount of energy in what people eat and drink) at 69 ml per hour (ml/hr) for 20 hours via pump to provide 1375 ml per 1200 kcal per day.<br><br>During a review of Resident 55's care plan (CP) on risk for but not limited to dehydration (a condition that occurs when the body does not have enough water and other fluids to carry out its normal functions), weight fluctuation, and nausea and vomiting last revised [DATE] with target date [DATE], the CP indicated to administer EF and flush G-tube with water as ordered as a few of the interventions.<br><br>During an on [DATE] at 9:50 a.m., inside Resident 55's room, observed resident lying in bed with the EF bottle and water flush bag hanging on the pole at the resident's bedside. The EF bottle and water flush bag tubing was connected to the resident's G-tube and was delivering the EF via pump with infusion rate at 69 ml/hr and the water flush at 60 ml/hr. The EF bottle and water flush bag did not indicate the rate of infusion.<br><br>During a concurrent observation and interview on [DATE] at 10:40 a.m., inside Resident 55's room with Registered Nurse 2 (RN 2), RN 2 stated the label on Resident 55's EF bottle and water flush bag did not indicate the rate of infusion. RN 2 stated all EF bottle and water flush bag labels should indicate the resident's name, the start date and time, and the infusion rate to ensure the resident was getting the correct amount of EF and water required to meet their needs.<br><br>During an interview on [DATE] at 3:00 p.m., with the Director of Nursing (DON), the DON stated all EF bottles and water flush bags are to be changed every 12 p.m. per facility practice. The DON stated prior to starting a new EF bottle and water flush bag, the licensed nurse should check the physician's order for accuracy and ensure the label indicated the resident's name, room number, the start date and time, and the infusion rate to ensure the resident was getting the correct amount of nutrition and hydration needed.<br><br>During a review of the facility's policy and procedure (P&P) titled, Enteral Tube Feeding via Gravity Bag, last reviewed on [DATE], the P&P indicated a purpose to provide nourishment to the resident who is unable to obtain nourishment orally. The P&P indicated to check the enteral nutrition label against the order before administration. The P&P indicated, on the formula label document initials, date, and time the formula was hung/administered, rate of administration (ml/hr), and initial that the label was checked against the order.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled, Supplemental Water Via Enteral Pump, last reviewed on [DATE], indicated that supplemental water will be supplied via enteral pump as ordered by the physician to ensure adequate hydration and assist in the prevention of but not limited to dehydration, G-tube clogging, and need to provide bolus flushing. The P&P indicated that the open system bag will be changed every 24 hours and should label the bag with the date and time, and rate of administration.<br><br>44244<br><br>4. During a review of Resident 80's Admission Record, the Admission Record indicated the facility admitted the resident on [DATE] and readmitted the resident on [DATE] with diagnoses that included frontal lobe (largest part of the brain) and executive function (skills used to manage everyday tasks) deficit (lack of) following nontraumatic intracerebral hemorrhage (a stroke, loss of blood flow to part of the brain which damages brain tissue), gastrostomy, and dysphagia (difficulty swallowing).<br><br>During a review of Resident 80's Minimum Data Set (MDS - an assessment and care screening tool), dated [DATE], the MDS indicated the resident was rarely/never able to understand others and was rarely/never able to make himself understood. The MDS indicated the resident required substantial/maximal assistance from staff for eating, oral hygiene, toileting, bathing, and dressing.<br><br>During a review of Resident 80's Physician Orders Summary Report, the report indicated orders for the following:<br><br>-Enteral feed order, Glucerna (specialized liquid medical food) 1.5 at 65 cubic centimeter (cc, a unit of measurement) per hour for 20 hours via pump (device used to deliver liquid nutrition) to provide 1300 cc / 1950 kilocalorie (Kcal, a unit of measurement of energy) per day, dated [DATE]<br><br>-Enteral feed order, every shift, check tube placement, dated [DATE].<br><br>-Enteral feed order, every shift monitor GT patency, dated [DATE].<br><br>During a review of Resident 80's Care Plan (CP) titled, (Resident 80) is on GT feeding. At risk for . infection at GT site, initiated [DATE], the CP indicated a goal to minimize the risk of feeding intolerance daily and to minimize the risk of infection and to check and maintain placement and patency of GT.<br><br>During an observation on [DATE] at 12:31 p.m., Resident 80 was lying in bed, observed the resident was disconnected from the EF and the EF pump was turned off. Observed LVN 3 enter Resident 80's room, donned gloves, walked over to Resident 80, exposed the resident's GT, connected the residents GT to the EF tubing, and started the pump to initiate the EF. Observed LVN 3 did not check placement of the GT prior to starting the EF. LVN 3 exited Resident 80's room.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a follow up interview on [DATE] at 12:40 p.m., with LVN 3, LVN 3 stated Resident 80's EF gets started at noon daily. LVN 3 stated he did not check for placement of Resident 80's GT prior to starting the EF, but he should have. LVN 3 stated placement of the GT is checked to ensure there is no flow of the feeding into the wrong place. LVN 3 stated GT placement is checked by using a stethoscope and listening to the resident's abdomen as a syringe is used to push air into the GT. LVN 3 stated there was not necessarily any reason why he did not check Resident 80's GT placement prior to starting the EF.<br><br>During an interview on [DATE] at 9:34 a.m., with Registered Nurse 3 (RN 3), RN 3 stated placement of the GT is checked prior to every use to ensure the GT is not dislodged. RN 3 stated it was standard nursing practice to check the GT placement because if the GT was not checked for placement and it was dislodged it could potentially cause an infection in the resident's stomach.<br><br>During a concurrent interview and record review on [DATE] at 1:50 p.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedure regarding EF. The DON stated the facility policy indicates every time something is introduced to the GT, placement of the GT should be checked. The DON stated LVN 3 did not follow the facility policy and it could potentially result in complications from the EF that could cause in infection in Resident 80's abdomen.<br><br>During a review of the facility policy and procedure titled, Enteral Tube Feeding via Gravity Bag, last reviewed [DATE], the policy indicated the purpose of the procedure was to provide nourishment to the resident who is unable to obtain nourishment orally. Use aseptic technique when preparing or administering enteral feedings. Verify placement of feeding tube. If anything suggests improper tube positioning, do not administer feeding. Notify the charge nurse or physician. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>43988<br><br>Based on observation, interview and record review, the facility failed to administer parenteral fluids (the intravenous administration of medication) consistent with professional standards of practice:<br><br>1. For one (1) out of two (2) sampled residents (Resident 445) during random observation of residents with intravenous (IV) catheter (a thin, flexible tube that is inserted into a vein to draw blood and give treatments including IV fluids, drugs, or blood transfusions) by:<br><br>a. Failing to ensure the IV fluid infusing on the left upper arm (LUA) midline (ML - a long, thin, flexible tube that is inserted into a large vein in the upper arm) was free from signs and symptoms of infiltration (a condition that occurs when the IV fluid or medication accidentally leaks into the surrounding tissues outside the intended vein).<br><br>b. Failing to document the dressing changes for the right upper arm (RUA) peripherally inserted central catheter (PICC - a thin, flexible tube that is inserted into a vein in the upper arm and guided into a large vein above the right side of the heart) line and LUA ML in the Medication Administration Record (MAR) on 9/3/2024.<br><br>c. Failing to document the PICC line and ML flushes in the MAR on 9/1/2024 and 9/4/2024 at 9 p.m.<br><br>These deficient practices placed the residents at risk for developing complications such as inflammation of the vein and infection.<br><br>2. For one of two sampled residents (Resident 60) investigated under hydration by failing to:<br><br>a. Clarify with the primary physician if the peripheral intravenous (I.V., into or within a vein) catheter (indwelling single-lumen plastic conduits that allow fluids, medications, and other therapies such as blood products to be introduced directly into a peripheral vein) was still needed post I.V. antibiotic completion.<br><br>b. Change the dressing of the peripheral I.V. catheter of the resident weekly.<br><br>c. Place a green cap (Curos, alcohol-containing caps that twist onto I.V. access points for disinfection and protection) on the flush port of the resident's peripheral I.V.<br><br>These deficient practices had the potential to result in Resident 60's peripheral I.V. site to develop an infection.<br><br>Findings:<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. During a review of Resident 445's Admission Record, the Admission Record indicated the facility admitted the resident on 8/1/2024 and readmitted in the facility on 8/29/2024 with diagnoses including but not limited to chronic respiratory failure (a long term condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and epilepsy (a brain condition that causes recurring seizures [abnormal electrical activity in your brain]).<br><br>During a review of Resident 445's History and Physical (H&P) dated 8/31/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 445's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/13/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).<br><br>During a review of Resident 445's Order Summary Report, the Order Summary Report indicated:<br><br>-8/29/2024: Central line and midline care as needed for wet, loose, or soiled dressings.<br><br>-8/29/2024: Central line and midline care every day shift every seven (7) days for site car. Change all central line, PICC, and ML transparent dressings per sterile technique (upon admission if not dated or site not visible for assessment). Change injection cap to each lumen. Change securement device.<br><br>-8/30/2024: Dextrose (a sterile solution used to provide the body with extra water and carbohydrates) five (5) percent (% - a unit of measurement) half (1/2 - a unit of measurement) normal saline (NS - a mixture of sterile water and sodium chloride [salt]) at 50 milliliters (ml - a unit of measurement) per hour for IV hydration every shift.<br><br>-8/29/2024: Peripheral IV flush order: flush with ten (10) milliliter (ml - a unit of measurement) NS before and after IV medications. Maintenance: flush with 10 ml NS every 12 hours.<br><br>-8/29/2024: Site check every shift. Site without signs and symptoms of complications and no adverse reactions from IV therapies unless addressed in nurse's notes every shift.<br><br>During a concurrent observation and interview on 9/3/2024 at 12:04 p.m., inside Resident 445's room with Registered Nurse 2 (RN 2), observed the resident's LUA ML transparent dressing dated 9/3/2024, with redness and swelling around the insertion site. RN 2 verified redness and swelling are signs and symptoms of infiltration. RN 2 stated IV sites are checked every shift for signs and symptoms of infection and are removed after a physician's order is obtained, to prevent complications such as inflammation of the vein and infection.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 9/5/2024 at 10:23 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 445's MAR for 9/2024 and Order Summary Report. RN 2 stated she did not document she changed the dressing on 9/3/2024. RN 2 stated she should have documented dressing change in the MAR, so the licensed nurses know when the next PICC line and ML dressing change is due and to prevent complications such as swelling and redness. RN 2 verified there was no documented evidence the injection ports were flushed per physician's order on 9/1/2024 and 9/4/2024 at 9 p.m. RN 2 stated the injection ports should have been flushed as ordered to ensure the ports are patent and to prevent complications such as swelling and infection.<br><br>During an interview on 9/6/202 at 2:25 p.m., with the Director of Nursing (DON), the DON stated if the IV line had signs and symptoms of infiltration during the assessment, the physician should be notified to obtain an order to discontinue the line. The DON stated IV sites should be checked and flushed as ordered by the physician to ensure the lines are patent and to prevent complications such as swelling and infection.<br><br>During a review of the facility's policy and procedure (P&P) titled, Midline Catheter Flushing, last reviewed 7/25/2024, the P&P indicated:<br><br>- A physician's order is required to flush a ML catheter and must include the flushing agent, strength/concentration, volume, and frequency.<br><br>- Catheters must be flushed with the prescribed flushing agent, instill flushing agent while observing for signs and symptoms of complications/infiltration.<br><br>- Document in the medical record the following but not limited to date and time, prescribed flushing agent, and site assessment.<br><br>During a review of the facility's P&P titled, Midline Catheter Dressing Change, last reviewed 7/25/2024, the P&P indicated:<br><br>- Dressing changes using transparent dressings are performed at least weekly.<br><br>- Change catheter securement device every seven (7) days and as needed.<br><br>- Label dressing with the date and time, and nurse's initials.<br><br>- Document in the medical records the following but not limited to date and time, and site assessment.<br><br>During a review of the facility's P&P titled, PICC Flushing, last reviewed 7/25/2024, the P&P indicated:<br><br>- A physician's order is required to flush a ML catheter and must include the flushing agent, strength/concentration, volume, and frequency.<br><br>- Catheters must be flushed with the prescribed flushing agent, instill flushing agent while observing for signs and symptoms of complications/infiltration.<br><br>(continued on next page) |

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| Sherman Village Hcc | 12750 Riverside Drive<br>North Hollywood, CA 91607 |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Document in the medical record the following but not limited to date and time, prescribed flushing agent, and site assessment.<br><br>During a review of the facility's P&P titled, PICC Line Dressing Change, last reviewed 7/25/2024, the P&P indicated:<br><br>- A physician's order is required to flush a ML catheter and must include the flushing agent, strength/concentration, volume, and frequency.<br><br>- Catheters must be flushed with the prescribed flushing agent, instill flushing agent while observing for signs and symptoms of complications/infiltration.<br><br>- Document in the medical record the following but not limited to date and time, prescribed flushing agent, and site assessment.<br><br>44376<br><br>2. During a review of Resident 60's Admission Record, the record indicated the facility admitted the resident on 8/8/2024, with diagnoses including gastrostomy (a surgical procedure used to insert a tube, often referred to as a g-tube, through the abdomen and into the stomach), tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow air to fill the lungs), and acute embolism (a blockage of a pulmonary [lung] artery).<br><br>During a review of Resident 60's History and Physical (H&P), dated 8/8/2024, the H&P indicated the resident did not have the capacity to make decisions.<br><br>During a review of Resident 60's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/15/2024, the MDS indicated the resident usually had the ability to make self-understood and understand others and had an antibiotic via I.V. access.<br><br>During a concurrent observation, interview, and record review on 9/3/2024, at 9:12 a.m., with Registered Nurse 1 (RN 1), inside Resident 60's room, observed Resident 60 with a peripheral I.V. on the left forearm, gauge 20, with a date of 8/24/2024, and with no green cap (Curos) on the I.V. flush port. RN 1 stated the peripheral I.V. dressing was dated 8/24/2024, and the dressing should have been changed on 8/31/2024 or weekly per facility policy. RN 1 stated the flush port of the peripheral I.V. should have been placed with a green cap (Curos) to prevent infection. RN 1 reviewed the resident's Order Summary Report and the Medication Administration Record (MAR). RN 1 stated the resident completed the antibiotics on 8/27/2024 and will contact the physician if the peripheral I.V. can be removed.<br><br>During an interview on 9/6/2024, at 2:01 p.m., with the Director of Nursing (DON), the DON stated the licensed nurse should have called the physician to discontinue the peripheral I.V. after completion of the I.V. antibiotic. The DON stated per policy they (licensed nurses) need to change the peripheral I.V. dressing every seven days and place a Curos cap on the I.V. injection site to prevent infection. The DON stated not discontinuing the I.V. as soon as possible when not needed, not changing the peripheral I.V. dressing every 7 days, and not placing a Curos cap on the I.V. injection site predisposed the resident to infection.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's recent policy and procedure titled, I.V. Physician Orders, last reviewed on 7/25/2024, the policy and procedure indicated dressing changes will occur with site change or at least every seven days and if needed (PRN).<br><br>During a review of the facility provided product information titled, Curos Disinfecting Cap for Needleless Connectors, undated, the product information indicated to always place a new Curos disinfecting cap on needleless connector after each use. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376<br><br>Based on observation, interview, and record review, the facility failed to assess the medical need, evaluate the risks of entrapment (a state in which a person is trapped by the bed rail [also known as side rails, a type of safety device that can be attached to a bed frame to help prevent falls and provide support for getting in and out of bed] in a position that they cannot move from), obtain an informed consent, and/or follow the physician's order for the use of bed rails and/or placement of pillows underneath the mattress for one of three sampled residents (Resident 46) investigated during review of bed rails and for two of five sampled residents (Resident 37 and 73) investigated during review of physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body).<br><br>These deficient practices placed the residents at risk for potential accident such as a body part being caught between the rails, falls if a resident attempts to climb over, around, between, or through the rails, restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, and death of residents.<br><br>Cross-reference F604 and F641.<br><br>Findings:<br><br>a. During a review of Resident 46's Admission Record, the record indicated the facility admitted the resident on 10/3/2020, and readmitted the resident on 4/23/2024, with diagnoses including quadriplegia (a condition where all four limbs experience paralysis), seizures (a sudden, uncontrolled burst of electrical activity in the brain that can cause changes in behavior, movement, and awareness), and traumatic brain injury (a form of acquired brain injury, occurs when a sudden trauma causes damage to the brain).<br><br>During a review of Resident 46's History and Physical (H&P), dated 4/23/2024, the H&P indicated the resident was incapacitated and had muscle weakness with limited movement, and required visit for safety.<br><br>During a review of Resident 46's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/14/2024, the MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, the basic tasks people perform to care for themselves and stay healthy).<br><br>During a review of Resident 46's Order Summary Report, dated 4/23/2024, the report indicated an order to apply bilateral padded half siderails as seizure precaution to minimize risks of injury. Informed consent obtained from resident representative (RP) by MD after explanation of risks and benefits, every shift.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 9/3/2024, at 11:12 a.m., with CNA 1, inside Resident 46's room, observed Resident 46's all four side rails in raised position. CNA 1 stated placing all four side rails up is considered a restraint.<br><br>During a concurrent interview and record review on 9/4/2024, at 2:33 p.m., with Registered Nurse (RN) 1, reviewed Resident 46's Order Summary Report, consents, assessments, and care plans. RN 1 stated there is no physician's order, no consent from the resident or resident representative, no assessment for bed entrapment, and no care plan for use of all four side rails in raised position. RN 1 stated it is important to ensure there was a physician's order, an assessment for entrapment, a consent from the resident or resident representative, and a care plan for side rail use to ensure the resident's safety and to honor the resident's right to accept or decline the use of restraint.<br><br>During an interview on 9/6/2024, at 2:01 p.m., with the DON, the DON stated it is important to have a physician's order, a consent from the resident or resident representative, an assessment for entrapment, and a care plan for use of all four side rails to ensure the interventions are safe and appropriate and to honor resident's right to refuse treatment if desired.<br><br>During a review of the facility's recent policy and procedure (P&P) titled, Bed Safety and Bed Rails, last reviewed on 7/25/2024, the (P&P) indicated before using bed rails for any reason, the staff shall inform the resident or resident representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent:<br><br>a. The assessed medical needs that will be addressed with the use of bed rails;<br><br>b. The resident's risk from the use of bed rails and how these will be mitigated;<br><br>h. The alternatives that were attempted but failed to meet the resident's needs; and<br><br>i. The alternatives that were considered but not attempted and the reasons.<br><br>43418<br><br>b. During a review of Resident 37's Admission Record, the admission record indicated the facility originally admitted Resident 37 on 4/12/2019 and readmitted the resident on 6/27/2022, with diagnoses including, but not limited to, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures [a sudden, uncontrolled burst of electrical activity in the brain that can cause temporary changes in a person's behavior, movements, feelings, and level of awareness]).<br><br>During a review of Resident 37's MDS, dated [DATE], the MDS indicated Resident 37 was rarely or never understood, was dependent on staff for ADLs such as eating, hygiene, toileting, dressing, bathing, and surface-to-surface transfers. The MDS further indicated bed rails and other types of restraints were not used.<br><br>During a review of Resident 37's H&P, dated 8/7/2024, the H&P indicated Resident 37 did not have the capacity to understand and make decisions.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 9/3/2024, at 10:07 a.m., inside Resident 37's room, Resident 37 was sleeping in bed, facing towards the resident's left side, towards the wall. Resident 37's bed was placed against the wall, in the far-right corner upon entry into the room, with the head of the bed pointing towards the room window, the foot of the bed pointing toward the doorway, and the left side of the bed against the wall. Resident 37's bed had two quarter rails on the head and foot of the right side of the bed. Resident 37's bed had pillows placed along the right side, under the mattress, and elevated the right side of the bed to slightly below the top of quarter rails.<br><br>During an observation on 9/5/2024, at 2:26 p.m., inside Resident 37's room, Resident 37 was sleeping in bed. Resident 37's bed had pillows placed underneath the right side of the mattress, creating an angled incline away from Resident 37's right side.<br><br>During a concurrent observation and interview with Restorative Nurse Aide (RNA) 2, on 9/5/2024, at 2:34 p. m., inside Resident 37's room, RNA 2 confirmed the presence of pillows underneath the right side of Resident 37's mattress and the bed rail at the right side of the head of the bed was up. RNA 2 stated Resident 37 is very active and makes attempts to jump out of the bed. RNA 2 stated Resident 37's certified nursing assistants (CNA) must have placed the pillows underneath the resident's mattress. RNA 2 further stated Resident 37's family sometimes puts the pillows under that mattress.<br><br>During an interview with Family Member (FM) 2, on 9/5/2024, at 2:53 p.m., FM 2 stated she is the family member of Resident 37 and prefers to have the pillows underneath the resident's mattress because the resident jumps out of the bed. FM 2 further stated she and the facility staff place the pillows underneath Resident 37's mattress.<br><br>During an interview with CNA 9, on 9/6/2024, at 9:07 a.m., CNA 9 stated she was assigned to Resident 37. CNA 9 stated Resident 37 attempts to jump out of his bed and pillows are placed underneath Resident 37's mattress to position his mattress at an angle so that the resident is more toward the wall of the room and to protect the resident.<br><br>During a concurrent observation and interview with the Minimum Data Set Coordinator (MDSC), on 9/6/2024, at 9:27 a.m., inside Resident 37's room, the MDSC confirmed Resident 37 had pillows placed underneath the right side of his mattress and that the pillows should not be placed there because it can be considered a restraint. The MDSC stated there have been instances where Resident 37 attempts to roll out of bed and the pillows placed under the mattress help keep him in place. The MDSC confirmed Resident 37 had quarter bed rails on the left and right side of his bed. The MDSC reviewed Resident 37's medical record and stated Resident 37 did not have an assessment performed for the use of pillows underneath the mattress and for bed rails. The MDSC further stated an assessment needs to be performed prior to the use of restraints to check if it is appropriate to use, to see if other less restrictive measures can be utilized, and to check for the safety of the resident.<br><br>During an interview with the DON, on 9/6/2024, at 2:01 p.m., the DON stated prior to obtaining a new order for the use of side rails for Resident 37, there was no entrapment risk assessment performed for the resident. The DON further stated it is important to perform an assessment prior to application of interventions to ensure the interventions were safe and to honor resident's right to refuse treatment if desired.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled, Bed Safety and Bed Rails, last reviewed on 7/25/2024, the P&P indicated before using bed rails for any reason, the staff shall inform the resident or resident representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent:<br><br>a. The assessed medical needs that will be addressed with the use of bed rails;<br><br>b. The resident's risk from the use of bed rails and how these will be mitigated;<br><br>h. The alternatives that were attempted but failed to meet the resident's needs; and<br><br>i. The alternatives that were considered but not attempted and the reasons.<br><br>43988<br><br>c. During a review of Resident 73's Admission Record, the Admission Record indicated the facility admitted the resident on 11/2/2023 and readmitted in the facility on 8/13/2024 with diagnoses including but not limited to chronic respiratory failure (a long term condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and epilepsy (.a common condition that affects the brain and causes frequent seizures [an abnormal electrical activity in the brain that temporarily affects consciousness, muscle control and behavior]).<br><br>During a review of Resident 73's H&P, dated 8/14/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 73's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all ADLs. The MDS indicated Resident 73 had impairment on both upper extremities.<br><br>During a review of Resident 73's Order Summary Report dated 8/13/2024, the Order Summary Report indicated:<br><br>- Bilateral upper half side rails up when in bed for safety and protection secondary to involuntary movement by gravity due to elevated head of bed for management of tracheostomy and provision of enteral feeding (EF - a type of liquid nutrition delivered through a flexible tube that goes in through the nose or directly into the stomach) [Informed consent obtained from responsible party after explanation of risks and benefits and verified with physician].<br><br>During a review of Resident 73's fall risk assessments dated 2/23/2024, 6/11/2024, 8/13/2024, and 8/23/2024, the fall risk assessments indicated Resident 73 was a high risk for falls.<br><br>During a review of Resident 73's informed consent, a consent for bilateral upper half siderails up when in bed for safety and protection, was obtained from the resident's responsible party (RP) on 8/13/2024.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 73's side rail/entrapment risk assessment form dated 8/13/2024, the side rail/entrapment risk assessment indicated a recommendation for bilateral half upper siderails.<br><br>During a concurrent observation, interview, and record review on 9/3/2024 at 11:36 a.m., inside Resident 73's room with RN 2, RN 2 stated the resident is lying in bed with four side rails in raised position. RN 2 stated the physician's order for side rails was not followed because the order dated 8/13/2024, indicated to use bilateral upper half side rails while the resident is in bed. RN2 stated using all four side rails restricts the resident's movement.<br><br>During a concurrent interview and record review on 9/4/2024 at 2:58 p.m., with MDSC, reviewed Resident 73's Order Summary Report. The MDSC stated Resident 73's physician's order indicated bilateral upper half siderails up while in bed. The MDSC verified the informed consent obtained from the RP and entrapment risk assessment conducted was for the order bilateral upper half siderails up when in bed. The MDSC stated the physician's order was not followed. The MDSC stated using four siderails up while Resident 73 is in bed is considered a restraint because the resident would be unable to get out of bed, restricting the resident's movement.<br><br>During a review of the facility's P&P titled, Physical Restraints, last reviewed 7/25/2024, the P&P indicated:<br><br>Physical restraints are any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body.<br><br>Less restrictive measures shall be attempted, and effectiveness of these measures is to be documented.<br><br>The interdisciplinary team (IDT - a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological, and spiritual needs of the patient) shall evaluate the outcome of all measures attempted and make recommendations accordingly.<br><br>The licensed nurse shall obtain an order from the attending physician, which is to include the specific type of restraint, purpose of the restraint, tie and place of application, approaches to prevent decreased functioning, and informed consent from resident or surrogate decision-maker.<br><br>During a review of the facility's P&P titled, Bed Safety and Bed Rails, last reviewed 7/25/2024, the P&P indicated:<br><br>Bed rails are adjustable metal or rigid plastic bars that attach to the bed, they are available in a variety of types, shapes, and sizes ranging from full to on-half, one-quarter, or one-eight lengths. Some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed; bed rails include side rails and safety rails and grab bars.<br><br>The use of bed rails or side rails including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Before using bed rails for any reason, the staff shall inform the resident or RP about the benefits and potential hazards associated with bed rails and obtain informed consent. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455<br><br>Based on interview and record review, the facility failed to ensure the consultant pharmacist's (CP) recommendation for July 2024 Medication Regimen Review (MRR) (a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) was carried out as per standard of care for one of five sampled residents (Resident 24) reviewed for unnecessary medications.<br><br>The deficient practice increased the risk of receiving medication that was not optimal for Resident 24's medical condition, that would not maintain the resident's highest level of physical, mental, and psychosocial well-being and/or increase the risk of adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) from the medication therapy.<br><br>Cross reference F758<br><br>Findings:<br><br>During a review of Resident 24's Admission Record (a document containing demographic and diagnostic information,) dated 9/4/24, the Admission Record indicated the resident was originally admitted to the facility on [DATE] diagnoses including Type 2 Diabetes Mellitus 2 ([DM2] - a condition where there is high blood sugar levels,) Depression (a condition where one has constant feelings of sadness and loss of interest) and Psychosis (a severe mental disorder that causes abnormal thinking and perception.)<br><br>During a review of Resident 24's Order Summary Report, dated 9/4/24, the report indicated Resident 24 was prescribed:<br><br>1. Escitalopram (generic name for Lexapro [a psychotropic (any medication capable of affecting the mind, emotions, and behavior) medication used to treat depression]) 5 milligram ([mg] - a unit of measure of mass) to give 1 tablet orally at bedtime for depression, starting 3/10/23<br><br>2. Lispro (short-acting insulin) to inject per sliding scale (insulin dosing plan whereby the amount of insulin administered depends on the resident's blood sugar level,) subcutaneous ([SQ] - under the skin) before meals and at bedtime for high blood sugar, starting 4/14/24.<br><br>During a review of Resident 24's Medication Administration Record ([MAR] - a record of mediations administered to residents), for September 2024, the MAR indicated Resident 24 was prescribed:<br><br>1. Escitalopram 5 mg to give 1 tablet orally at bedtime for depression, at 9 PM<br><br>2. Lispro to give per sliding scale SQ before meals and at bedtime for high blood sugar, at 6:30 AM, 11:30 AM, 4:30 PM and 9 PM.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 24's Psychotropic Summary Sheet for Escitalopram 5 mg for Depression, the sheet indicated Resident 24 had no documented behaviors of depression between 1/1/24 and 6/30/24.<br><br>During a review of Resident 24's MAR for June, July, August, September 2024, the MARs indicated Resident 24 had no documented behaviors of depression between 1/1/24 and 6/30/24.<br><br>During a review of the MRR note for Resident 24 by the Consultant Pharmacist (CP,) titled Note to Attending Physician/Prescriber and dated 7/19/2024, it indicated Noted that the patient's glucose level was 190 (obtained on 4/2024). Please consider ordering a HgA1C (a blood test that measures average blood sugar level over the past 2-3 months) for monitoring of blood sugar control. Document a dose reduction if appropriate. If therapy is to continue, please document risk versus benefit assessment. The document was marked with a check mark in the DISAGREE box with a handwritten note stating, Per MD no labs, Hospice patient end of life comfort measures and was dated 7/23/24. The document contained no signatures.<br><br>During a review of the MRR note for Resident 24 by the CP, titled Note to Attending Physician/Prescriber and dated 7/19/2024, indicated Resident has been taking Lexapro 5 mg daily, since 3/2023. Please consider a dose reduction if appropriate. If therapy to continue, please document risk versus benefit assessment.<br><br>___Clinically contraindicated because target symptoms returned or worsened after a past GDR.<br><br>___ Clinically contraindicated because any additional GDR would impair the resident's function.<br><br>___ Will attempt a dose reduction. Please see MD orders.<br><br>Ref: Federal guidelines recommend a gradual dose reduction on two separate quarters in the first year and then at least once a year thereafter, unless clinically contra-indicated (SOM; F-758: unnecessary medications). The document was not marked for the listed selections and was marked with a handwritten note stating, MD disagrees, continue with current orders as part of end of life comfort measures and was dated 7/23/24. The document contained no signatures.<br><br>During a Review of Resident 24's clinical record, it indicated no HgA1C level was obtained, and no dose reduction was attempted for Lexapro 5 mg daily.<br><br>During an interview and concurrent clinical record, MAR, and MRR on 9/5/24 at 12:09 PM, with the Director of Nursing (DON,) the DON stated that Resident 24 was enrolled in Hospice (care for residents focusing on quality of life during a resident's end of life) program. The DON stated that Resident 24's clinical record does not contain an order from the physician or Hospice to stop laboratory services/obtaining blood labs. The DON stated the DON was unable to locate a HgA1C level for Resident 24 in the last 3 months. The DON stated that HgA1C levels should be checked to make sure the blood sugar levels are managed properly for the Resident's DM. The DON stated without monitoring HgA1C levels it will be unknown if insulin Lispro is affective or not, leading to the use of unnecessary (any medication in excessive dose, excessive duration, without adequate monitoring) medications. The DON stated that the facility failed to obtain an HgA1C level as per standard of practice and CP recommendation on 7/19/24 for Resident 24.<br><br>(continued on next page) |

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| | 056159 | A. Building<br>B. Wing | 09/06/2024 |

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| Sherman Village Hcc | 12750 Riverside Drive<br>North Hollywood, CA 91607 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During the same interview, the DON stated that Resident 24 does not have documented behaviors of depression since 1/2024, and that Lexapro 5 mg daily was continued without an attempt for GDR. The DON stated that there should have been an attempt for a GDR for Lexapro 5 mg daily or a documentation in the psychiatry notes indicating a clinical rationale for continuing and what contraindications prevented the GDR. The DON stated it was important to properly assess the absence of behaviors and consider GDR to ensure Resident 24 was receiving treatment that was optimal for Resident's condition and to maintain their highest level of well-being. The DON stated the facility failed to document a clinical rational for continuing Lexapro 5 mg daily for Resident 24.<br><br>During the same interview, the DON stated because of failing to provide a clinical rationale for continuing Lexapro 5 mg daily without an attempt for GDR and failing to obtain HgA1C level, Resident 24 was placed at risk of continuing unnecessary medications including psychotropic medications that could result in adverse consequences and side effects, negatively impacting the resident's well health and well-being. The DON stated the DON will now have to review all Hospice orders and coordinate the care with them to ensure resident care plans were implemented as indicated and for the residents to maintain their highest practicable self in the absence of adverse effects.<br><br>During a review of the facility's Policy & Procedures (P&P) titled Hospice Program, dated July 2017, the P&P indicated:<br><br>10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure the level of care provided is appropriately based on the individual resident's needs.<br><br>13. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services by our facility .in order to maintain the resident's highest practicable physical, mental and psychosocial well-being.<br><br>During a review of the facility's P&P titled Adverse consequences and Medication Errors, dated March 2023, the P&P indicated:<br><br>2. An 'adverse consequence' is defined as an unpleasant symptoms or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include:<br><br>a. adverse drug/medication reaction<br><br>b. side effect<br><br>4. The staff and practitioner shall strive to minimize adverse consequences by:<br><br>a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication.<br><br>During a review of the facility's P&P titled Medication Therapy, dated April 2007, the P&P indicated:<br><br>Policy Statement<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. Each resident's medication a regiment shall include only those medications necessary to treat existing conditions and address significant risks.<br><br>3. All medication orders will be supported by appropriate care processes and practices.<br><br>Policy Interpretation and Implementation<br><br>2. All decisions related to medications shall include appropriate elements of the care process such as:<br><br>a. Adequately detailed assessment<br><br>c. Consideration of the clinical relevance of symptoms and abnormal diagnostic test results<br><br>3. Upon or shortly after admission and periodically thereafter the staff and practitioner (assisted by the consultant pharmacist) will review and individuals current medication regimen to identify whether<br><br>a. There is a clear indication for treating that individual with the medication<br><br>b. The dosage is a appropriate<br><br>5. The Physician will identify situations where medications should be tapered, discontinued, or changed to another medication, for example:<br><br>a. When a medication is being given in excessive dose, for excessive periods of time, and without adequate monitoring or in the absence of a valid clinical rationale.<br><br>During a review of the facility's P&P titled Medication Regimen Review (Monthly Report), dated April 2008, the P&P indicated that The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing and the attending Physician and if appropriate the medical director and/or the administrator.<br><br>E 2. If there is potential for serious harm and the attending Physician does not concur or the attending Physician refuses to document explanation for disagreeing the director of nursing or designee contact the medical director.<br><br>During a review of the facility's P&P titled Psychotropic Medication Use, dated October 2017, the P&P indicated that A psychotropic drug is any medication that affects brain activities associated with mental processes and behavior, which includes but is not limited to antipsychotics, anxiolytics, hypnotics, and antidepressants.<br><br>The Facility should comply with the State Operations Manual, and all other Applicable Law relating to the use of psychoactive medications, including gradual dose reductions.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5c. GDR may be considered clinically contraindicated for reasons that include, but that are not limited to:<br><br>ii. The physician as document and a clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.<br><br>8. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.<br><br>9a. Physician/Prescriber should document the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>43455<br><br>Based on interview and record review, the facility failed to ensure residents' drug regimen was free from unnecessary drugs (any drug in excess) for one of five sampled residents (Resident 24) reviewed for unnecessary medication. Resident 24's duplicate medication orders for the same indication remained as active drugs on the Medication Administration Record ([MAR]- a record of medications administered to a resident) and were administered since 5/25/2024.<br><br>This deficient practice had the potential to cause Residents 24 to receive suboptimal (less than the highest standard or quality) care and increase the risk of adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) and health complications.<br><br>Findings:<br><br>During a review of Resident 24's Medication Administration Record ([MAR] - a record of mediations administered to residents,) for September 2024, indicated that the resident was prescribed and had an active order for:<br><br>1. Claritin (a medication used for pruritis [itching]) 10 milligrams ([mg] - a unit of measure of mass) to give 1 tablet orally twice a day for pruritis at 9 AM and 5 PM, starting 2/19/24, and<br><br>2. Vistaril (a medication used for itching) 25 mg to give 1 tablet orally twice a day for itching at 9 AM and 5 PM, starting 5/25/24.<br><br>During a review of Resident 24's May, June, July, August, and September 2024 MARs indicated that Claritin 10 mg and Vistaril 25 mg were signed off as administered twice a day, at 9 AM and 5 PM.<br><br>During a review of Skin Rash Reports, the reports indicated that Resident 24 did not complain of itching on 6/18/24, did not complain of itching on 8/1/24 and a comment indicating No itchiness present or noted, and on 8/6/24 a comment indicating resolved.<br><br>During an interview on 9/5/24 at 11:25 AM, with Registered Nurse (RN) 4 from Hospice program (program that provides care for people with serious illnesses who are near the end of their lives,) RN 4 stated that Resident 24 was prescribed Claritin on 2/19/24 and Vistaril on 5/25/24 both for itching. RN 4 stated Resident 24 had itching in May 2024 that was resolved in June 2024. RN 4 stated once symptoms resolve then medications for those symptoms were no longer needed and would be discontinued after a short time. RN 4 stated that RN 4 usually visits Resident 24 on a weekly basis and reviews the medication list. RN 4 stated that during the visits since June 2024 Claritin and Vistaril were not discontinued and will do so now as Resident 24's itching had resolved.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview and concurrent review on 9/5/24 at 12:09 PM, with the Director of Nursing (DON,) Resident 24's clinical record, MAR and Skin Rash Report were reviewed. The DON stated that Resident 24 was enrolled in Hospice (care for residents focusing on quality of life during a resident's end of life) program. The DON stated that Resident 24 did not have documented itching after June 18, 2024, all of July, August and up to date September 2024. The DON stated that Resident 24 had duplicate medication order for itching and that the DON was unable to find a clinical rationale to continue both Claritin and Vistaril for Resident 24. The DON stated that it was important to review medications timely to ensure residents were receiving treatment that was optimal for their condition and were not placed at risk of continuing unnecessary meds that could result in adverse consequences and side effects, negatively impacting their health and well-being. The DON stated that the facility failed to discontinue duplicate medications (Claritin and Vistaril) for Resident 24 after the itching had resolved in June 2024, and that the DON will now have to review all hospice orders and coordinate the care with them to ensure residents care plans are implemented to maintain their highest practicable self in the absence of adverse effects.<br><br>During a review of the facility's policy and procedures (P&P) titled Medication Administration, dated October 2017, the P&P indicated If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis conditions, the nurse calls the provider pharmacy for clarification prior to administration of the medication or if necessary, contacts the prescriber for clarification.<br><br>During a review of the facility's P&P titled Medication Therapy, dated April 2077, the P&P indicated:<br><br>1. Each resident's medication regiment shall include only those medications necessary to treat existing conditions and address significant risks.<br><br>3. Upon or shortly after admission, and periodically thereafter, the staff and practitioner .will review an individual's current medication regimen, to identify whether:<br><br>c. The frequency of administration and duration of use are appropriate.<br><br>During a review of the facility's P&P titled Hospice Program, dated July 2017, the P&P indicated:<br><br>10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure the level of care provided is appropriately based on the individual resident's needs.<br><br>13. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services by our facility .in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455<br><br>Based on interview and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 24) drug regimen was free from the use of unnecessary (any medication in excessive dose, excessive duration, without adequate monitoring) psychotropic (any medication capable of affecting the mind, emotions, and behavior) medications in accordance with the facility policy and procedure by failing to:<br><br>1. Indicate a specific duration for the use of Pro Re Nata ([PRN]- as needed) lorazepam (a psychotropic medication used to treat anxiety, also known as anxiolytic) order.<br><br>2. Provide a detailed clinical rationale for continuing Escitalopram (generic name for Lexapro [a psychotropic (any medication capable of affecting the mind, emotions, and behavior) medication used to treat depression]) as originally prescribed on 3/10/2023.<br><br>These deficient practices increased the risk that Residents 24 may have experienced adverse effects (unwanted or dangerous medication side effects) of psychotropic medication therapy leading to an overall negative impact on their physical, mental, and psychosocial well-being.<br><br>Cross reference F756<br><br>Findings:<br><br>During a review of Resident 24's Admission Record (a document containing demographic and diagnostic information,) dated 9/4/2024, the record indicated the resident was originally admitted to the facility on [DATE] diagnoses including Type 2 diabetes mellitus 2 ([DM2] - a condition where there is high blood sugar levels,) dementia (loss of memory and other mental abilities severe enough to interfere with daily life,) depression (a condition where one has constant feelings of sadness and loss of interest) and Psychosis (a severe mental disorder that causes abnormal thinking and perception.)<br><br>During a review of Resident 24's Order Summary Report, dated 9/4/24, indicated Resident 24 was prescribed:<br><br>1. Lorazepam 0.5 milligram ([mg] - a unit of measure of mass) 1 tablet by mouth every 6 hours as needed for anxiety/restlessness, starting 6/11/24.<br><br>2. Escitalopram 5 mg to give 1 tablet orally at bedtime for depression, starting 3/10/23.<br><br>During a review of Resident 24's Medication Administration Record ([MAR] - a record of mediations administered to residents), for September 2024, the MAR indicated Resident 24 was prescribed:<br><br>1. Lorazepam 0.5 mg to give 1 tablet orally every 6 hours as needed for anxiety/restlessness, scheduled PRN.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. Escitalopram 5 mg to give 1 tablet orally daily at bedtime for depression, at 9 PM.<br><br>During a review of Resident 24's Psychotropic Summary Sheet for Escitalopram 5 mg for Depression, the sheet indicated Resident 24 had no documented behaviors of depression between 1/1/24 and 6/30/24.<br><br>During a review of Resident 24's MAR for June, July, August, September 2024, the MARs indicated Resident 24 had no documented behaviors of depression between 1/1/24 and 6/30/24.<br><br>During a review of Resident 24's clinical record, the clinical record indicated that the facility did not indicate a stop date or specify a duration for the lorazepam PRN order, and no dose reduction was attempted for Lexapro 5 mg daily.<br><br>During a review of the MRR note for Resident 24 by the Consultant Pharmacist (CP,) titled Note to Attending Physician/Prescriber and dated 7/19/2024, it indicated Resident has been taking Lexapro 5 mg daily, since 3/2023. Please consider a dose reduction if appropriate. If therapy to continue, please document risk versus benefit assessment.<br><br>___Clinically contraindicated because target symptoms returned or worsened after a past Gradual Dose Reduction (GDR).<br><br>___ Clinically contraindicated because any additional GDR would impair the resident's function.<br><br>___ Will attempt a dose reduction. Please see MD orders.<br><br>Ref: Federal guidelines recommend a gradual dose reduction on two separate quarters in the first year and then at least once a year thereafter, unless clinically contra-indicated (SOM; F-758: unnecessary medications). The document was not marked for the listed selections and was marked with a handwritten note stating, MD disagrees, continue with current orders as part of end of life comfort measures and was dated 7/23/24. The document contained no signatures.<br><br>During an interview and concurrent review on 9/5/2024 at 12:09 PM, with the Director of Nursing (DON,) Resident 24's clinical record, MAR, and MRR were reviewed. The DON stated that Resident 24 was enrolled in Hospice (care for residents focusing on quality of life during a resident's end of life) program. The DON stated that the facility policy was to have specific duration for PRN psychotropic medications, and that it was important to do so to ensure psychotropic medications do not cause more harm than good. The DON stated that the DON was unable to locate a stop date or a specific duration for the lorazepam order in Resident 24's clinical chart. The DON stated unnecessary use of psychotropic medications such as lorazepam can cause significant adverse effects, such as drowsiness, dizziness, dry mouth, tardive dyskinesia (uncontrolled face muscle movements,) akathisia (inability to hold still,) leading to a decline in resident's quality of life. The DON stated that the facility failed to include a stop date or duration for Resident 24's PRN lorazepam order.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During the same interview, the DON stated that Resident 24 does not have documented behaviors of depression since 1/2024, and that Lexapro 5 mg daily was continued without an attempt for GDR. The DON stated that there should have been an attempt for a GDR for Lexapro 5 mg daily or a documentation in the psychiatry notes indicating a clinical rationale for continuing and what contraindications prevented the GDR. The DON stated it was important to properly assess the absence of behaviors and consider GDR to ensure Resident 24 was receiving treatment that was optimal for Resident's condition and to maintain their highest level of well-being. The DON stated the facility failed to document a clinical rational for continuing Lexapro 5 mg daily for Resident 24.<br><br>During the same interview, the DON stated because of failing to provide a clinical rationale for continuing Lexapro 5 mg daily without an attempt for GDR and failing to add a stop date or duration to the PRN lorazepam order, Resident 24 was placed at risk of continuing unnecessary medications including psychotropic medications that could result in adverse consequences and side effects, negatively impacting the resident's well health and well-being. The DON stated the DON will now have to review all Hospice orders and coordinate the care with them to ensure resident care plans were implemented as indicated and for the residents to maintain their highest practicable self in the absence of adverse effects.<br><br>During a review of the facility's Policy and Procedures (P&P) titled Psychotropic Medication Use, dated October 2017, the P&P indicated that A psychotropic drug is any medication that affects brain activities associated with mental processes and behavior, which includes but is not limited to antipsychotics, anxiolytics, hypnotics, and antidepressants.<br><br>The Facility should comply with the State Operations Manual, and all other Applicable Law relating to the use of psychoactive medications, including gradual dose reductions.<br><br>2. Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic drugs are limited to 14 days.<br><br>a. For psychotropic prn medications, excluding antipsychotics, if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>5c. GDR may be considered clinically contraindicated for reasons that include, but that are not limited to:<br><br>ii. The physician as document and a clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.<br><br>8. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 9a. Physician/Prescriber should document the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.<br><br>During a review of the facility's P&P titled Medication Therapy, dated April 2007, the P&P indicated:<br><br>5. The Physician will identify situations where medications should be tapered, discontinued, or changed to another medication, for example:<br><br>a. When a medication is being given in excessive dose, for excessive periods of time, and without adequate monitoring or in the absence of a valid clinical rationale.<br><br>During a review of the facility's P&P, titled Adverse consequences and Medication Errors, dated March 2023, the P&P indicated The interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions and side effects.<br><br>3. An 'adverse consequence' is defined as an unpleasant symptoms or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include:<br><br>a. adverse drug/medication reaction<br><br>b. side effect<br><br>3. An 'adverse drug reaction', a form of adverse consequence, is defines as a secondary and usually undesirable effect of a drug and is different from the therapeutic and helpful effects of the drug.<br><br>4. The staff and practitioner shall strive to minimize adverse consequences by:<br><br>a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication.<br><br>7. The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis.<br><br>8. When a resident receives a new medication, the medication order is evaluated for the following:<br><br>a. The dose, route of administration, duration.<br><br>During a review of the facility's Policy & Procedures (P&P) titled Hospice Program, dated July 2017, the P&P indicated:<br><br>10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure the level of care provided is appropriately based on the individual resident's needs.<br><br>(continued on next page) |

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| | 056159 | A. Building<br>B. Wing | 09/06/2024 |

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| Sherman Village Hcc | 12750 Riverside Drive<br>North Hollywood, CA 91607 |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 13. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services by our facility .in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>43455<br><br>Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than 5 percent (%) due to 2 errors observed out of 31 total opportunities (error rate of 6.45%). The medication errors were as follows:<br><br>1. Resident 67 received a dose ascorbic acid (a medication used to improve the immune system) that was not ordered by Resident 67's physician.<br><br>2. Resident 74 did not receive multivitamin (a medication used as a dietary supplement to provide essential vitamins, minerals, and other nutritional elements) with iron (a supplement used to treat iron deficiency [having low amounts of iron in the blood] and anemia [a condition with lower-than-normal number of red blood cells]) as ordered by Resident 74's physicians.<br><br>These failures had the potential to result in Residents 67 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Resident 67's and 74's health and well-being to be negatively impacted.<br><br>Cross reference F760<br><br>Findings:<br><br>During an observation on 9/4/2024 at 9:17 AM, in Medication Cart Subacute 1, Licensed Vocational Nurse (LVN) 2 was observed administering ascorbic acid 500 milligram ([mg]-a unit of measure of mass) tablet crushed (pressed very hard so that the shape is destroyed and formed into a soft powder) via gastrostomy tube ([G-tube] - a tube inserted through the belly that brings nutrition directly to the stomach) to Resident 67 followed by administration of 10 ml of water though the tube.<br><br>During an interview on 9/4/2024 at 10:13 AM, with LVN 2, LVN 2 stated that LVN 2 administered ascorbic acid 500 mg to Resident 67 on 9/4/2024 at 9:17 AM. LVN 2 stated all medication orders must have the medication name, dose/strength specified, and that the ascorbic acid for Resident 67 does not have the dose/strength specified. LVN 2 stated that LVN 2 failed to clarify the dose/strength of the ascorbic acid with the physician and failed by administering ascorbic acid 500 mg to Resident 67 without an order indicating to do so. LVN 2 stated this is a medication error. LVN 2 stated that LVN 2 will contact the physician to clarify the dose/strength of ascorbic acid for Resident 67.<br><br>During an observation on 9/4/2024 at 9:37 AM, in Medication Cart SNF 1, LVN 3 was observed not administering multivitamin with iron tablet to Resident 74. Resident 74 was observed swallowing several other medications whole with sips of water and was observed not being administered the multivitamin with iron.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 9/4/2024 at 10:29 AM, with LVN 3, LVN 3 stated that Resident 74's multivitamin with iron tablets was not available in the medication cart or in the facility. LVN 3 stated that LVN 3 needed to contact the pharmacy to check on the multivitamin with iron tablet order for Resident 74. LVN 3 stated that this was considered a medication error because Resident 74's multivitamin with iron was not administered. LVN 3 stated not administering the multivitamin with iron can cause Resident 74's anemia to get worse and cause the resident to experience adverse effects. LVN 3 stated that usually medications should be requested for refill from medication available at the scheduled times.<br><br>During an interview on 9/5/2024 at 2:48 PM, with Director of Nursing (DON), the DON stated that all medication orders must have the medication name, dose, frequency, route, and indication. The DON stated that LVN 2 failed to clarify the dose/strength of the ascorbic acid order before administering the medication to Resident 67. The DON stated that LVN 2 administered ascorbic acid 500 mg to Resident 67 without an order indicating to do so. The DON also stated that several LVN's failed to timely request a refill of multivitamin with iron for Resident 74 to ensure the medication was available at time of administration. The DON stated as a result the facility did not receive Resident 74's supply of multivitamin with iron tablets, and the resident did not receive a dose on 9/4/2024 by LVN 3. The DON stated these were considered medication errors.<br><br>During a review of Resident 67's Medication Administration Record ([MAR] - a record of mediations administered to residents,) for September 2024, the MAR indicated Resident 67 was prescribed ascorbic acid 1 tablet to be given via G-tube once a day for supplement at 9 AM, starting 9/3/24 until 9/13/24. The physician orders did not indicate the strength of the ascorbic acid. The clinical record contained no documentation that the resident should be given a dose of ascorbic acid 500 mg.<br><br>During a review of Resident 74's MAR for September 2024, the MAR indicated Resident 74 was prescribed multivitamin with iron to be 1 tablet orally once a day for iron deficiency at 9 AM, starting 4/29/2024. The clinical record contained no documentation that the resident should not be given a dose of multivitamin with iron.<br><br>During a review of the facility's policy and procedures (P&P), titled Medication Administration-General Guidelines, dated October 2017, the P&P indicated that Medications are administered as prescribed in accordance with good nursing principles and practices .<br><br>Preparation<br><br>3. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label.<br><br>Administration<br><br>2. Medications are administered in accordance with written orders of the attending physician.<br><br>10. Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after) .<br><br>During a of the facility's P&P, titled Medication Orders, dated July 2016, the P&P indicated that:<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 9. Orders for medications must include:<br><br>a. Name and strength of the drug<br><br>11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available.<br><br>During a review of the facility's P&P, titled Ordering and Receiving Medications from The Dispensing Pharmacy, dated April 2008, the P&P indicated that Medications and related products are received from the dispensing pharmacy on a timely basis.<br><br>2a. Reorder medications five days in advance of need to assure an adequate supply is on hand.<br><br>During a review of the facility's P&P, titled Adverse consequences and Medication Errors, dated March 2023, the P&P indicated:<br><br>2. An 'adverse consequence' is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include:<br><br>a. Adverse drug/medication reaction<br><br>b. Side effect<br><br>4. The staff and practitioner shall strive to minimize adverse consequences by:<br><br>a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication;<br><br>5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.<br><br>6. Examples of medication error include:<br><br>a. Omission - a drug is ordered but not administered;<br><br>g. Wrong time<br><br>h. Failure to follow manufacturer instructions and/or accepted professional standards. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376<br><br>Based on observation, interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) by failing to:<br><br>1. Rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous ([SQ] -beneath the skin) insulin [a medication used to regular blood sugar levels] and enoxaparin (a blood thinner) administration sites for five of ten sampled residents (Resident 24, 43, 60, 61 and 85) investigated under insulin and enoxaparin.<br><br>2. Have six licensed vocational nurses (LVNs) not administer expired insulin to one of five sampled residents (Resident 85) investigated for insulin.<br><br>3. Administer Metoprolol Succinate (medication dosed once a day to treat high blood pressure) Extended Release ([ER] - a medication formulation that is released over a 24 hour period) once a day between [DATE] and [DATE] to one of four sampled residents (Resident 548) observed for medication administration.<br><br>These deficient practices increased the risk that Residents 24, 43, 60, 61, 85 and 548 could experience adverse effects (unwanted, unintended result) from same site subcutaneous administration of insulin and enoxaparin such as bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin,) and extremely low blood pressure and heart rate.<br><br>Cross Reference F658, F759, F761<br><br>Findings:<br><br>a. During a review of Resident 61's Admission Record, the Admission Record indicated the facility admitted the resident on [DATE], with diagnoses including type 2 diabetes mellitus (a disease that occurs when the blood glucose, also called blood sugar, is too high), protein-calorie malnutrition (a nutritional condition that occurs when the body does not get enough protein, energy, and other essential nutrients), and diabetic chronic kidney disease (a condition that occurs when diabetes damages the kidneys over time)<br><br>During a review of Resident 61's History and Physical (H&P), dated [DATE], the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 61's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others. The MDS indicated the resident had severely impaired cognitive skills (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life) and was on a high-risk drug class hypoglycemic (a class of medications that lower blood sugar levels) including insulin.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 61's Order Summary Report, the report indicated the following physician's orders:<br><br>Dated [DATE]: Lantus Subcutaneous Solution (Insulin Glargine, a long-acting, synthetic version of human insulin). Inject 15 unit (the biological equivalent of 34.7 micrograms of pure crystalline insulin) subcutaneously at bedtime for hyperglycemia (a condition that occurs when there is too much sugar, or glucose, in the blood).<br><br>Dated [DATE]: Novolog Injection Solution (Insulin Aspart, a rapid-acting, human insulin). Inject as per sliding scale (varies the dose of insulin based on blood sugar level): if ,d+[DATE]= 0; ,d+[DATE]= 3; ,d+[DATE]= 5; , d+[DATE]= 8; ,d+[DATE]= 10; ,d+[DATE]= 12 blood sugar (BS) greater than (>) 400 give 15 unit and contact the MD, subcutaneously every 6 hours for blood sugar monitoring.<br><br>During a review of Resident 61's Location of Administration Report on the use of insulin for the month of , d+[DATE] to ,d+[DATE], the Location of Administration Report indicated insulin Aspart was administered on:<br><br>[DATE] at 12:22 a.m. on the Abdomen- Left Upper Quadrant (LUQ)<br><br>[DATE] at 12:15 a.m. on the Abdomen-LUQ<br><br>[DATE] at 6:04 a.m. on the Abdomen- Right Upper Quadrant (RUQ)<br><br>[DATE] at 5:03 a.m. on the Abdomen-RUQ<br><br>[DATE] at 6:05 a.m. on the Abdomen- Left Lower Quadrant (LLQ)<br><br>[DATE] at 5:16 a.m. on the Abdomen-LLQ<br><br>[DATE] at 12:11 p.m. on the Abdomen-RUQ<br><br>[DATE] at 6:04 p.m. on the Abdomen-RUQ<br><br>[DATE] at 12:01 a.m. on the Arm-left<br><br>[DATE] at 6:56 a.m. on the Arm-left<br><br>[DATE] at 5:21 p.m. on the Abdomen-RUQ<br><br>[DATE] at 8:11 p.m. on the Abdomen-RUQ<br><br>During a concurrent interview and record review on [DATE], at 2:44 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 61's Order Summary Report and Location of Administration of insulin for ,d+[DATE] to , d+[DATE]. RN 1 stated there were multiple instances where the administration sites of insulin for ,d+[DATE] to ,d+[DATE] were not rotated. RN 1 stated the sites for insulin administration should be rotated to prevent lipodystrophy that can affect the absorption of the medication. RN 1 stated not rotating insulin administration sites were considered as a medication error.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE], at 2:01 p.m., with the Director of Nursing (DON), the DON stated the staff should have rotated the insulin administration sites to prevent lipodystrophy and cutaneous amyloidosis on residents. The DON stated not rotating insulin administration sites were considered as a medication error.<br><br>During a review of the facility's recent policy and procedure titled, Adverse Consequences and Medication Errors, last reviewed on [DATE], the policy and procedure indicated a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services.<br><br>During a review of the facility's recent policy and procedure titled, Insulin Administration, last reviewed on [DATE], the policy and procedure indicated to select an injection site.<br><br>a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel.<br><br>b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).<br><br>During a review of the facility- provided Highlights of Prescribing Information on the use of Insulin Aspart injection, for subcutaneous or intravenous use, with initial U.S. approval in 2000, the highlights of prescribing information indicated to rotate injection sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis.<br><br>b. During a review of Resident 60's Admission Record, the Admission Record indicated the facility admitted the resident on [DATE], with diagnoses including type 2 diabetes mellitus, long term use of insulin, and atrial fibrillation (a type of irregular heartbeat, or arrhythmia, that occurs when the heart's upper chambers beat irregularly and rapidly).<br><br>During a review of Resident 60's H&P, dated [DATE], the H&P indicated the resident did not have the capacity to make decisions.<br><br>During a review of Resident 60's MDS, dated [DATE], the MDS indicated the resident usually make self-understood and understand others. The MDS indicated the resident was on a high-risk drug class anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the heart) and hypoglycemic including insulin.<br><br>During a review of Resident 60's Order Summary Report, the report indicated physicians' orders:<br><br>Dated [DATE]: Insulin Lispro Injection Solution 100 unit/milliliters (ml, a unit of volume) (Insulin Lispro, a rapid-acting, synthetic version of human insulin). Inject as per sliding scale: if ,d+[DATE]= 2 less than 150- 0 unit; ,d+[DATE]= 4; ,d+[DATE]= 7; ,d+[DATE]= 10; ,d+[DATE]= 13 greater than 400 call MD, subcutaneously every 6 hours for diabetes mellitus type 2 (DM 2) (Rotate site).<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Dated [DATE]: Lovenox Injection Solution Prefilled Syringe 80 milligrams (mg, a unit of weight) /0.8 ml (enoxaparin Sodium). Inject 80 mg subcutaneously every 12 hours for deep vein thrombosis (DVT, the formation of one or more clots) prophylaxis (an attempt to prevent disease) (Rotate abdominal site). Discontinued on [DATE].<br><br>During a review of Resident 60's Location of Administration Report on the use of Lovenox and insulin for , d+[DATE] to ,d+[DATE], the report indicated Lovenox was administered on:<br><br>[DATE] at 5:42 a.m. on the Abdomen-LLQ<br><br>[DATE] at 5:39 p.m. on the Abdomen-LLQ<br><br>And insulin Lispro was administered on:<br><br>[DATE] at 5:34 a.m. on the Abdomen-LUQ<br><br>[DATE] at 5:32 a.m. on the Abdomen-LUQ<br><br>During a concurrent interview and record review on [DATE], at 2:50 p.m., with RN 1, reviewed Resident 60's Order Summary Report, Location of Administration Report on the use of Lovenox and insulin for ,d+[DATE] to ,d+[DATE]. RN 1 stated there were instances where Lovenox and insulin administration sites were not rotated from ,d+[DATE] to ,d+[DATE]. RN 1 stated Lovenox and insulin sites of administration should be rotated to prevent bruising of the skin for Lovenox and lipodystrophy on the use of insulin. RN 1 stated not rotating Lovenox and insulin administration sites were considered as a medication error.<br><br>During an interview on [DATE], at 2:01 p.m., with the DON, the DON stated the staff should have rotated the insulin administration sites to prevent lipodystrophy and cutaneous amyloidosis on residents. The DON also stated Lovenox administration sites should be rotated to prevent bruising in the frequented sites of administration. The DON stated the failure of the licensed staff to rotate insulin and Lovenox administration sites were considered a medication<br><br>43455<br><br>c. During a review of Resident 24's Admission Record (a document containing demographic and diagnostic information,) dated [DATE], the Admission Record indicated the resident was originally admitted to the facility on [DATE] diagnoses including Type 2 Diabetes Mellitus 2 ([DM2] - a condition where there is high blood sugar levels.)<br><br>During a review of Resident 24's Order Summary Report, dated [DATE], the Order Summary Report indicated Resident 24 was prescribed Lispro (short-acting insulin) to inject per sliding scale (insulin dosing plan whereby the amount of insulin administered depends on the resident's blood sugar level,) subcutaneous ([SQ] - under the skin) before meals and at bedtime for high blood sugar, starting [DATE].<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 24's Medication Administration Record ([MAR] - a record of mediations administered to residents), for August and [DATE], the MARs indicated Resident 24 was prescribed insulin Lispro 20 to give per sliding scale SQ before meals and at bedtime for high blood sugar, at 6:30 a.m, 11:30 a. m., 4:30 p.m., and 9 p.m.<br><br>During the same review, the MARs indicated insulin Lispro SQ was administered on the following days and sites:<br><br>[DATE] at 9 PM on Right Upper Quadrant ([RUQ] - upper right side of abdomen)<br><br>[DATE] at 6:30 AM on RUQ<br><br>[DATE] at 9 PM on Left Upper Quadrant ([LUQ] - upper left side of abdomen)<br><br>[DATE] at 6:30 AM on LUQ<br><br>[DATE] at 4:30 PM on LUQ<br><br>[DATE] at 4:30 PM on LUQ<br><br>d. During a review of Resident 43's Admission Record dated [DATE], the Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including DM2.<br><br>During a review of Resident 43's Order Summary Report, dated [DATE], the Order Summary Report indicated Resident 43 was prescribed Lantus (long-acting insulin) to inject 14 units ([un] - a measure of dosage for insulin) SQ in the morning for DM hold if blood sugar less than 100 (Rotate injection site,) starting [DATE], and Novolog to inject per sliding scale SQ every 6 hours for DM2 Rotate injection site, starting [DATE].<br><br>During a review of Resident 43's MAR for [DATE], the MAR indicated Resident 43 was prescribed Lantus 10 units SQ in the morning for DM hold if blood sugar less than 100 at 9 AM, between [DATE] and [DATE], Lantus 14 un SQ in the morning for DM hold if blood sugar less than 100 (Rotate injection site) at 9 AM, starting [DATE], Novolog per sliding scale SQ every 6 hours for DM2 Rotate injection site at 12 AM, 6 AM, 12 PM and 6 PM, between [DATE] and [DATE], Novolog per sliding scale SQ every 6 hours for DM2 Rotate injection site at 12 AM, 6 AM, 12 PM and 6 PM, starting [DATE].<br><br>During the same review, the MAR's indicated Lantus SQ was administered on the following days, times and sites:<br><br>[DATE] at 9 AM on RUQ<br><br>[DATE] at 9 AM on RUQ<br><br>[DATE] at 9 AM on Left Lower Quadrant ([LLQ] - lower left side of abdomen)<br><br>[DATE] at 9 AM on LLQ<br><br>(continued on next page) |

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| | 056159 | A. Building<br>B. Wing | 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Sherman Village Hcc | 12750 Riverside Drive<br>North Hollywood, CA 91607 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During the same review, the MAR indicated Novolog SQ was administered on the following days, times and sites:<br><br>[DATE] at 12 PM on RUQ<br><br>[DATE] at 12 PM on RUQ<br><br>[DATE] at 12 PM on LLQ<br><br>[DATE] at 6 PM on LLQ<br><br>e. During a review of Resident 85's Admission Record dated [DATE], the Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including DM2.<br><br>During a review of Resident 85's Order Summary Report, dated [DATE], the Order Summary Report indicated Resident 85 was prescribed Humulin R (short-acting insulin) insulin per sliding scale SQ two times a day for DM2 (rotate injection site,) starting [DATE].<br><br>During a review of Resident 85's MAR for [DATE], the MAR indicated Resident 85 was prescribed Humulin R insulin per sliding scale SQ two times a day for DM2 (rotate injection site,) at 6:30 AM and 9 PM.<br><br>During the same review, the MARs indicated Humulin R insulin SQ was administered on the following days, times and sites:<br><br>[DATE] at 6:30 AM on RUQ<br><br>[DATE] at 6:30 AM on RUQ<br><br>During a review of Resident 85's MAR for August and [DATE], the MARs indicated Resident 85 received 25 doses of expired Humulin R insulin from the following nurses on the following dates and times:<br><br>LVN 7 - 12 doses at 6:30 AM (on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE])<br><br>LVN 8- 7 doses at 9 PM (on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE])<br><br>LVN 9 - 1 dose at 9 PM (on [DATE])<br><br>LVN 10 - 2 doses at 6:30 AM (on [DATE] and [DATE])<br><br>LVN 5 - 2 doses at 9 PM (on [DATE] and [DATE])<br><br>LVN 11 - 1 dose at 9 PM (on [DATE])<br><br>f. During a review of Resident 548's Admission Record dated [DATE], the Admission Record indicated the resident was originally admitted to the facility on [DATE] with a diagnosis including Hypertension (high blood pressure.)<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 548's Order Summary Report, dated [DATE], the Order Summary Report indicated Resident 548 was prescribed Metoprolol Succinate ER tablet 24 hour 50 milligram ([mg]-a unit of measure of mass) to give 1 tablet orally twice a day for hypertension, starting [DATE].<br><br>During a review of Resident 548's MAR for [DATE], the MAR indicated Resident 548 was prescribed Metoprolol Succinate ER tablet 24 hour 50 mg to give 1 tablet orally twice a day for hypertension, at 9 AM and 5 PM.<br><br>During an observation on [DATE] at 9:37 AM, in Medication Cart SNF 2, licensed vocational nurse (LVN) 4 was observed administering Metoprolol Succinate ER 24 hour 50 mg tablet to Resident 548. Resident 56 was observed swallowing the Metoprolol Succinate ER 24 hour 50 mg tablet whole with cranberry juice.<br><br>During an interview on [DATE] at 1:29 PM, with LVN 4, LVN 4 stated that Metoprolol Succinate ER tablet 24 hour tablets should be administered once a day and not twice a day, as the medication is formulated to be long acting. LVN 4 stated that Resident 548 was administered Metoprolol Succinate ER tablet 24 hour 50 mg tablet twice a day since [DATE]. LVN 4 stated that administering Metoprolol Succinate ER tablet 24 hour 50 mg tablet twice a day was considered overdosing (giving more than the recommended amount) and can cause harm by lowering the blood pressure and heart rate to dangerous levels for Resident 548.<br><br>During an observation on [DATE] at 2:04 PM, in Medication Cart 2, in the presence of LVN 5, the following medication was found either stored in a manner contrary to their respective manufacturer's requirements, expired and not discarded, or stored and labeled contrary to facility policies:<br><br>1. One open Humulin R insulin vial for Resident 85 was found stored at room temperature with a label indicating that storage at room temperature began on [DATE].<br><br>According to the manufacturer's product labeling, opened Humulin R insulin vials should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 31 days of opening or once storage at room temperature began.<br><br>During a concurrent interview with LVN 5, LVN 5 stated that the Humulin R insulin multi-dose (containing more than one dose) vial for Resident 85 was open and labeled with a date indicating that use began on [DATE]. LVN 5 stated that most insulin vials expire within 30 days of opening the vial, and that the Humulin R vial for Resident 85 expired on [DATE] and should be removed from the medication cart. LVN 5 stated that Humulin R doses administered to Resident 85 after [DATE] came from that expired vial, and no other vial was opened or used. LVN 5 stated administering expired insulin will not be effective in keeping the blood sugar stable and can harm Resident 85 by causing high or low blood sugar levels, leading to coma (a state of deep unconsciousness caused by injury or illness), hospitalization or even death. LVN 5 stated the insulin Humulin R vial needs to be immediately replaced with a new one from pharmacy for Resident 85.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on [DATE] at 2:17 PM, with Licensed Vocational Nurse (LVN) 4, LVN 4 reviewed Resident 24's MAR for August and [DATE], and Resident 43's and 85's MAR for [DATE]. LVN 4 stated that Resident 43's MAR indicated to rotate injection sites for Lantus and Novolog, and Resident 85's MAR indicated to rotate injection site for Regular insulin. LVN 4 stated that for Resident 24, 43 and 85 the MARs indicated there were multiple instances where the insulin administration sites were not rotated by several licensed nurses, as expected by standard of practice, manufacturer guidelines, and MAR order instructions. LVN 4 stated the failure of the licensed nurses to rotate insulin administration sites could cause harm to Resident 24, 43 and 85 by causing skin abnormalities such as lumps in the skin or thickened skin.<br><br>During an interview on [DATE] at 2:48 PM, with Director of Nursing (DON), the DON stated that the insulin Humulin R vial for Resident 85 was expired and should have been removed from the medication cart. The DON stated several LVN's failed to remove expired insulin Humulin R from the medication cart, which lead to the administration of expired insulin to Resident 85 resulting in significant medication error. The DON stated that expired insulins have lost potency (the strength of medication) and effectiveness and when administered in error will not be effective in controlling blood sugar levels leading to hyperglycemia (high blood sugar levels) and adverse effects for Resident 85, requiring change of condition and additional laboratory testing.<br><br>During the same interview, the DON stated that per facility policy and manufacturer guidelines it was common knowledge for licensed nurses to rotate insulin administration sites to prevent lipodystrophy (thickened skin) to the sites that was frequently administered with insulin. The DON stated that several licensed nurses failed to rotate the insulin administration sites for Resident 24, 43 and 85 and placed the residents at risk of harm from lipodystrophy. The DON stated not rotating insulin administration sites was considered a significant medication error.<br><br>During the same interview, the DON stated that per manufacturer guidelines Metoprolol Succinate ER 24 hour tablets should be administered once a day because the medication was released over 24 hours. The DON stated that Metoprolol Succinate ER lowers blood pressure and heart rate and administering twice a day cause harm to Resident 548 by lowering the blood pressure and heart rate below normal levels. The DON stated that the facility failed identify the medication discrepancy for twice a day administration of Metoprolol Succinate ER 24 hour tablets since [DATE] for Resident 548. The DON stated that the DON would contact the physician and obtain new orders for Metoprolol for Resident 548.<br><br>During an interview on [DATE] at 1:29 PM, with LVN 4, LVN 4 stated that Metoprolol Succinate ER tablet 24 hour tablets should be administered once a day and not twice a day, as the medication is formulated to be long acting. LVN 4 stated that Resident 548 was administered Metoprolol Succinate ER tablet 24 hour 50 mg tablet twice a day since [DATE]. LVN 4 stated that administering Metoprolol Succinate ER tablet 24 hour 50 mg tablet twice a day was considered overdosing (giving more than the recommended amount) and can cause harm by lowering the blood pressure and heart rate to dangerous levels for Resident 548.<br><br>Review of the facility's Policy and Procedures (P&P,) titled Adverse consequences and Medication Errors, dated [DATE], the P&P indicated:<br><br>2. An 'adverse consequence' is defined as an unpleasant symptoms or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | a. adverse drug/medication reaction<br><br>b. side effect<br><br>4. The staff and practitioner shall strive to minimize adverse consequences by:<br><br>a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication;<br><br>5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.<br><br>5. Examples of medication error include:<br><br>h. Failure to follow manufacturer instructions and/or accepted professional standards.<br><br>A review of facility's P&P titled, Insulin Administration, dated [DATE], indicated: To provide guidelines for the safe administration of insulin to residents with diabetes.<br><br>3. The type of insulin, .and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order.<br><br>4. Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening).<br><br>16.a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel.<br><br>16.b. injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).<br><br>A review of manufacturer's guide for Injecting Lantus with a vial and syringe, dated 2022, the guide indicated to Change (rotate) your injection sites within the area you chose with each dose to reduce your risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred or damaged.<br><br>A review of manufacturer's guide for Instructions for use for Novolog, dated ,d+[DATE], the guide indicated Injection sites should be rotated within the same region to reduce the risk of lipodystrophy. For each injection, change (rotate) your injection site within the area of skin that you use. Do not use the same injection site for each injection.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of manufacturer's guide for Instructions for use for Lispro, dated 1996, the guide indicated Long-term use of insulin, , can cause lipodystrophy at the site of repeated insulin injections or infusion. Lipodystrophy includes lipohypertrophy (thickening of adipose tissue) and lipoatrophy (thinning of adipose tissue), and may affect insulin absorption. Rotate insulin injection or infusion sites within the same region to reduce the risk of lipodystrophy.<br><br>A review of the facility provided Highlights of Prescribing Information for Humalog (insulin lispro injection, USP [rDNA origin]) for injection, with initial U.S. approval in 1996, the highlights of prescribing information indicated HUMALOG administered by subcutaneous injection should be given in the abdominal wall, thigh, upper arm, or buttocks. Injection sites should be rotated within the same region (abdomen, thigh, upper arm, or buttocks) from one injection to the next to reduce the risk of lipodystrophy.<br><br>A review of the facility provided Highlights of Prescribing Information for Lovenox (enoxaparin sodium) injection, for subcutaneous and intravenous use, with initial U.S. approval in 1993, the highlights of prescribing information indicated to alternate injection sites between the left and right anterolateral and left and right posterolateral abdominal wall.<br><br>A review of manufacturer's guide for Instructions for use for Regular Insulin, dated 2011, the guide indicated Injection sites should be rotated within the same region.<br><br>A review of facility's P&P, titled Vials and Ampules of Injectable Medications, dated [DATE], the P&P indicated that Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal.<br><br>F. Medication in multi-dose vials may be used until the manufacturer's expiration date or 6 months after opening unless otherwise specified.<br><br>A review of facility's P&P, titled Medications with Shortened Expiration Dates, [undated], the P&P listed the following:<br><br>Humulin R - Regular Human Insulin - Stability, In-use, room temperature vial: 31 days.<br><br>A review of manufacturer's guide Highlights of Prescribing Information for Metoprolol Succinate Extended Release, with initial U.S. approval in 1992, dated ,d+[DATE], the highlights of Dosage and Administration section indicated Administer once daily. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455<br><br>Based on observation, interview, and record review the facility failed to remove and discard from use one expired insulin (medication used to regulate blood sugar levels) Humulin R (short-acting insulin) vial for Resident 85, in accordance with manufacturer's requirements in one of three inspected medication carts (Medication Cart 2.)<br><br>This practice increased the risk that Residents 85 could have received medication that had become ineffective or toxic due to improper storage or labeling, possibly leading to health complications resulting in hospitalization or death.<br><br>Cross reference F760<br><br>Findings:<br><br>During an observation on [DATE] at 2:04 PM, in Medication Cart 2, in the presence of Licensed Vocational Nurse (LVN) 5, the following medication was found either stored in a manner contrary to their respective manufacturer's requirements, expired and not discarded, or stored and labeled contrary to facility policies:<br><br>1. One open insulin Humulin R vial for Resident 85 was found stored at room temperature with a label indicating that storage at room temperature began on [DATE].<br><br>According to the manufacturer's product labeling, opened Humulin R vials should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 31 days of opening or once storage at room temperature began.<br><br>During a concurrent interview with LVN 5, LVN 5 stated that the Humulin R insulin multi-dose (containing more than one dose) vial for Resident 85 was open and labeled with a date indicating that use began on [DATE]. LVN 5 stated that most insulin vials expire within 30 days of opening the vial, and that the Humulin R vial for Resident 85 expired on [DATE] and should be removed from the medication cart. LVN 5 stated that Humulin R doses administered to Resident 85 after [DATE] came from that expired vial, and no other vial was opened or used. LVN 5 stated administering expired insulin will not be effective in keeping the blood sugar stable and can harm Resident 85 by causing high or low blood sugar levels, leading to coma (a state of deep unconsciousness caused by injury or illness), hospitalization or even death. LVN 5 stated the insulin Humulin R vial needs to be immediately replaced with a new one from pharmacy for Resident 85.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 10:52 AM, with Director of Nursing (DON), the DON stated that the insulin Humulin R vial for Resident 85 was expired and should have been removed from the medication cart. The DON stated several LVN's failed to remove expired insulin Humulin R from the medication cart, which lead to the administration of expired insulin to Resident 85 resulting in significant medication error. The DON stated that expired insulins have lost potency (the strength of medication) and effectiveness and when administered in error will not be effective in controlling blood sugar levels leading to hyperglycemia (high blood sugar levels) and adverse effects for Resident 85, requiring change of condition and additional laboratory testing.<br><br>During a review of facility's policy and procedures (P&P,) titled Storage of Medications, dated [DATE], the P&P indicated that Medications and biologicals ae stored safely, and properly, following manufacturer's recommendations or those of the supplier.<br><br>-M. Outdated, contaminated, or deteriorated medications .are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists.<br><br>During a review of facility's P&P, titled Insulin Administration, dated [DATE], the P&P indicated: To provide guidelines for the safe administration of insulin to residents with diabetes.<br><br>4. Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening).<br><br>During a review of facility's P&P, titled Vials and Ampules of Injectable Medications, dated [DATE], the P&P indicated that Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal.<br><br>B. The date opened and the initials of the first person to use the vial are recorded on multi-dose vials.<br><br>F. Medication in multi-dose vials may be used until the manufacturer's expiration date or 6 months after opening unless otherwise specified.<br><br>During a review of facility's P&P, titled Medications with Shortened Expiration Dates, [undated], the P&P listed the following:<br><br>Humulin R - Regular Human Insulin - Stability, In-use, room temperature vial: 31 days. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441<br><br>Based on observation, interview, and record review the facility failed to follow the menu and did not meet nutritional needs of 2 of 3 residents (Resident 29 and Resident 39) on Renal diet (diets that are restricting food high in salt, potassium, and phosphorus due to kidney disease) by not using the correct scoop or utensil to ensure accurate portion sizes.<br><br>This deficient practice had the potential to cause increased in potassium (an essential mineral the body needs to function properly), sodium (an element found in salt), phosphorus (a mineral that naturally occurs in many foods that play roles in the body) intake and decrease food intake resulting to weight loss.<br><br>Findings:<br><br>During a review of Resident 29's Admission Record, the admission record indicated the facility initially admitted Resident 29 on 11/23/2021 then readmitted on [DATE] with diagnoses including, but not limited to, end stage renal disease (final, permanent stage, when kidneys could no longer function on its own), dependence on renal dialysis (a procedure that removes waste and extra fluid from the blood when kidneys are unable to do so) and type 2 diabetes mellitus (a disease that occurs when your blood glucose (blood sugar) is too high).<br><br>During a review of Resident 29's Minimum Data Set ([MDS) a standardized assessment and care screening tool), dated 6/5/2024, the MDS indicated Resident 29 was able to understand and make decisions, requires partial/moderate assistance with eating.<br><br>During a review of Resident 29's Order Summary Report, dated 9/3/2024, the report indicated Resident 29's diet order was renal 80 grams protein diet, soft bite sized texture, consistent carbohydrate ([CCHO], servings of carbohydrate is consistent in each meal to help control blood sugar levels).<br><br>During a review of Resident 29's care plan dated 11/29/2021, the care plan indicated Resident 29 was at risk for weight gain, weight loss, dehydration, skin alteration, elimination problems, malnutrition with interventions of diet as ordered.<br><br>During a review of Resident 39's Admission Record, the admission record indicated the facility admitted Resident 39 on 1/24/2024 with diagnoses including, but not limited to, chronic kidney disease (a reduced in kidney function associated loss of kidney function overtime), unspecified protein calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function) and type 2 diabetes mellitus.<br><br>During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39 was unable to understand and make decisions, requires partial/moderate assistance with eating.<br><br>During a review of Resident 39's Order Summary Report, dated 9/3/2024, the report indicated Resident 39's diet order was renal 80 grams protein diet, mechanical soft (foods that are soft and chopped) texture, thin consistency.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 39's care plan dated 1/29/2020, the care plan indicated Resident 39 has a goal to minimize the risk of weight loss daily.<br><br>During a review of the facility's menu spreadsheet (a list containing types and amount of foods of what each diet type would receive) titled Fall Menus-(Pg2) dated 9/3/2024, Tuesday, indicated residents on the following diets would receive half (1/2) cup ([c], a unit of measurement) wheat pasta:<br><br>Renal diet, 60 grams protein low potassium, low salt.<br><br>Renal diet, 80 grams protein, low potassium, low salt.<br><br>Renal diet, Consistent Carbohydrate diet, low potassium, low salt.<br><br>During a trayline (an area where food was assembled) observation on 9/3/2024 at 11:45 a.m., [NAME] 1 used a tong instead of scoop when portioning wheat pasta for renal diets.<br><br>During a concurrent observation of trayline for lunch service and interview with the Dietary Supervisor (DS) on 9/3/2024 at 11:56 a.m., the DS stated [NAME] 1 did not use the scoop when portioning the wheat pasta and had to use a scoop, however this was because pasta noodles was too long. The DS stated the renal diet portion for wheat pasta was half (1/2) a cup and staff needed to use the right utensils which was a gray scoop. The DS stated staff needed to follow the spreadsheet and follow the resident's diet. The DS stated if residents received more, they could gain weight and if less they could lose weight without trying as a potential outcome.<br><br>During a phone interview with the Registered Dietitian (RD) on 9/4/2024 at 12:00 p.m., the RD stated she provided kitchen oversight to ensure staff were following menus, spreadsheets, portion sizes and staff were using the correct scoops. The RD stated staff had to use scoop when portioning pasta. The RD stated staff could not get the exact measurement using tongs and if staff used the incorrect scoops sizes, they would not be giving appropriate portions to the residents which could cause weight gain or weight loss. The RD stated residents would not be getting adequate calories or protein and what they would need to get depending on their diets. The RD stated she had not trained the staff regarding portion sizes and scoops.<br><br>During a review of facilities' Policies and Procedures (P&P) titled Menus dated 7/25/2024, the P&P indicated Twenty-eight-day cycle menus are prepared by the dietitian and modifications of individual resident menus are made necessary to comply with physician orders and/or residents' preferences. Not less than three meals are served daily, with alternate selections daily. The standard menu will ensure nutritional adequacy of all diets, offer a variety of food in adequate amounts at each meal, and a standardized food production. (2) The menu cycle is extended for production on sheets for regular diets, as well as, any therapeutic diets available in the facility. Other commonly used diets may also be included on the production sheets. Standard combination diets will be posted. (5) The menus will be prepared as written standardized recipes. (7) Individual resident trays will have a meal ticket which identifies the residents name, room number, diet order. Also stated on the card: portion size. Meal tickets are periodically checked by the Dietary Services Supervisor and/or Consultant Dietitian for accuracy.<br><br>During a review of facilities' recipe titled RECIPE: SEASONED WHEAT PASTA dated 2024, indicated Portion Size: 1/2 cup. Special Diets: Renal Diet: May give.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of facilities' diet manual titled RENAL DIET 40-60-80 GRAM PROTEIN, LOW POTASSIUM, LOW SALT MENU dated 2020 indicated DESCRIPTION: This diet is used for the resident with renal insufficiency or for residents with renal failure not on dialysis. This diet regulates the dietary intake of sodium, potassium, and protein to lighten the work of the diseased kidney. This diet has three restrictions. Each restriction has a specific plan in this manual. This diet is also low in phosphorus. This diet is approximately 1800-2100 calories. Note: Residents on dialysis need to have specific protein level ordered by M.D., e.g. 60, 80 gm protein levels or higher. The diet order should also include other restrictions such as potassium, sodium, and fluid. Low potassium and low salt diet recommended.<br><br>During a review of facilities' diet manual titled RENAL 80 GRAM PROTEIN, LOW SALT, LOW POTASSIUM, IN COMBINATION WITH CONTROLLED CARBOHYDRATE DIET (CCHO) dated 2020 indicated Description: This diet is used for the diabetic resident with renal insufficiency at the 80-gm level of protein, low salt, and low potassium. It is then combined with CCHO.<br><br>During a review of facility's record of in-service training titled Following Spreadsheet dated 7/11/2024, it indicated an instructor provided training to staff regarding following portion control and appropriate scoop based on spreadsheet. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>47441<br><br>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when:<br><br>a. Refrigerators one (1) and refrigerator two's (2) vent and fan had dust build up.<br><br>b. Walk-in refrigerator and walk-on freezer's shelves were not smooth, cracked and had amber discoloration.<br><br>c. Staff were wearing watches, gold bracelet and three (3) rings.<br><br>d. Ice machine room floor was dusty.<br><br>e. One (1) of four (4) shelves was not six (6) inches ([in.], unit of measurement) or more from the floor.<br><br>These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (transfer of bacteria from one object to another) in 65 of 100 medically compromised residents who received food and ice from the kitchen.<br><br>Findings:<br><br>a. During an observation of Refrigerator 2 on 9/3/2024 at 8:07 a.m., the refrigerator fan had dust.<br><br>During a concurrent observation of Refrigerator 2 and interview with Dietary Supervisor (DS) on 9/3/2024 at 8:21 a.m., the DS sated they cleaned the refrigerators as needed and when they spilled something they had to clean it right away. The DS stated the fan in the Refrigerator 2 was not clean and it was dusty. The DS stated maintenance staff were responsible in cleaning the fan in the refrigerators. The DS stated it was important to maintain the refrigerator cleanliness due to infection control. The DS stated cross-contamination of dust to food could be a potential outcome to the residents.<br><br>During a concurrent observation of Refrigerator 1 near the dry storage area and interview with the DS on 9/3/2024 at 8:23 a.m., the DS stated the vent in Refrigerator 1 was dirty with dust accumulation. The DS stated it needed to be cleaned to avoid cross-contamination that could make the residents sick.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, Refrigerators and Freezer, dated 7/25/2024, the P&P indicated This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. (11) Refrigerators and freezers are kept clean, free of debris, and disinfected with sanitizing solution on a scheduled basis and more often as necessary.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Food Code 2017, it indicated 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. (B) NonFood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris.<br><br>b. During an observation of the walk-in refrigerator shelves on 9/3/2024 at 8:10 a.m., the walk-in refrigerator shelves were cracked, not smooth and had amber discoloration.<br><br>During an observation of the walk-in freezer on 9/3/2024 at 8:16 a.m., the walk-in freezer shelves had amber discoloration.<br><br>During a concurrent observation of the walk-in refrigerator and walk-in freezer and interview with DS on 9/3/2024 at 8:25 a.m., the DS sated the shelves in the walk-in refrigerator and freezer needed to be repainted or replaced with new shelves because shelves were rusty. The DS stated rusty shelves were not good because it could contaminate the resident's food and residents could get sick; however, the DS was not sure what type of sickness it could cause the residents.<br><br>During a review of the facility's P&P titled, Refrigerator and Freezers, dated 7/25/2024, indicated (10) Supervisors inspect refrigerator and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. Necessary repairs are initiated immediately. Maintenance schedules per manufacture guidelines are scheduled and followed.<br><br>During a review of Food Code 2017 indicated 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections.<br><br>c. During an observation of the dishwashing process on 9/3/2024 at 9:45 a.m., Diet Aide 1 (DA 1) was wearing a wristwatch and three (3) rings while putting away clean dishes.<br><br>During an observation of trayline (an assembly area for resident's foods in the tray) on 9/3/2024 at 11:45 a.m. , DA 1 was wearing wristwatch and 3 rings and Dietary Aide 2 was wearing wristwatch while placing food on the resident's trays.<br><br>During an observation of trayline on 9/3/2024 at 11:53 a.m., [NAME] 2 was wearing a gold bracelet while dishing out food from the steam table to the resident's plate.<br><br>During a concurrent observation of trayline and interview with the DS on 9/3/2024 at 11:59 a.m., the DS stated kitchen staff could wear wedding rings and small earrings only. The DS stated [NAME] 1 and DA 1 were wearing wristwatch, 3 rings and gold bracelet in trayline and it would not be okay as the jewelries could touch the food. The DS stated the jewelries contained germs and could cause cross-contamination.<br><br>During an observation for dinner food preparation on 9/3/2024 at 1:38 p.m., [NAME] 2 was wearing dangling gold bracelet on his right hand while cooking and stirring soup.<br><br>During a review of facility's P&P titled Sanitation and Infection Control dated 7/25/2024, the P&P indicated Food service employees will follow infection control policies to ensure the department operates under sanitary conditions at all times. Personal Hygiene ((9) No dangling jewelry or earrings should be worn. Only wedding rings are acceptable.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Food Code 2017, it indicated 2-303.11 Prohibition. Except for a plain ring such as wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands.<br><br>d. During a concurrent observation of the ice machine room and interview with DS on 9/3/2024 at 2:08 p.m. the DS stated the room floor was dusty and dirty. DS stated it needed to be cleaned to prevent cross-contamination.<br><br>During a review of the facility's P&P titled Maintenance and Plant Operations dated 7/25/2024 indicated This chapter describes the policies and procedures related to maintenance of the physical plant. Maintenance of a safe, sanitary environment ensures safety, affords protection, and enhances well-being of the residents, public and staff.<br><br>During a review of the facility's P&P titled Ice Machine Cleaning dated 7/25/2024, it indicated theDSS will schedule maintenance staff the cleaning of ice machine (motor) every three to six months, per manufacturer's guidelines.<br><br>During a review of Food Code 2017, it indicated 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301-3-306.<br><br>e. During concurrent observation of the disaster water supply besides the laundry room and interview with DS on 9/4/2024 at 10:16 a.m., 1 of 4 shelves was not 6 in. from the ground. DS stated it was important to have the shelves more than 6 in. high from the ground so they could clean the bottom portion of the shelves for infection control.<br><br>During a review of the facility's P&P titled Storage of Canned and Dry Goods dated 7/25/2024, the P&P indicated (5) Food and supplies will be stored 12 inches of the floor to prevent contamination and allow thorough cleaning. |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>47441<br><br>Based on observation, interview, and record review the facility failed to have a policy regarding the use and storage of food brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption when the policy did not include the facility's responsibility for storing food brought in by family and other visitors for more than one meal and there was no designated refrigerator for resident's outside food sources.<br><br>This deficient practice had the potential to cause a decrease food intake resulting to unintentional (without trying) weight loss, frustrations, and psychosocial harm to 65 of 100 facility residents.<br><br>Findings:<br><br>A review of the facility's Policies and Procedures (P&P) untitled dated 7/23/2024, the P&P indicated Policy: Food from the outside sources is discouraged due to concerns with food safety and infection control and maintaining control of therapeutic diet orders. PROCEDURE:<br><br>1. While it is preferred the families and/or friends do not bring foods or beverages into the facility, it is within the resident's rights to eat outside food, especially if the resident is eating poorly. If outside food is brought in, the facility is not liable for any food safety and infection control concerns.<br><br>2. If the resident, family member or friend wants to bring the resident an outside food or beverage, the resident family member, or friend should first check with the charge nurse or Dietary Service Supervisor to determine if the outside food or beverage is within the resident's prescribed diet.<br><br>3. The charge nurse must be notified if any outside food or beverage is brought in. It is recommended that only enough food/beverage be brought for visit/meal with the resident. The staff will discard any leftovers.<br><br>During an interview with Dietary Supervisor (DS) on 9/3/2024 at 1:46 p.m., the DS stated she was not sure if the nurse's station had a refrigerator designated to store resident's food.<br><br>During an interview with Registered Nurse 3 (RN 3) on 9/4/2024 at 9:50 a.m., RN 3 stated they did not allow storage of resident's food from the outside however its part of the resident's rights to bring food from the outside. RN 3 stated she was not sure about the policy regarding food from the outside source for the residents but did not want the residents to choke hence they checked for resident's diet, diet consistency and allergies and if the family requested for it. RN 3 stated they did not have any refrigerator to store resident's food in the nurse's station however they might have a refrigerator in the kitchen designated for resident's food from the outside. RN 3 stated it was important to refrigerate food as the food would spoil and residents could have diarrhea if they ate the food that was sitting out.<br><br>(continued on next page) |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview with the Director of Nursing (DON) on 9/4/2024 at 10:00 a.m., the DON stated they did not have any refrigerator in the nurse's station or in the facility for food from the outside sources for residents. The DON stated they instructed resident's family and visitors to only bring non-perishable and dry food and if they brought perishable food, it had to be for one meal only. The DON stated she would ask the family or visitors to come back the next day if they brought more food in the facility. The DON stated leftovers would be discarded. The DON stated there would be emotional harm as a potential outcome if they did not accept food from the visitors or family. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Dispose of garbage and refuse properly.<br><br>47441<br><br>Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly by not maintaining the trash area free from trash, soiled gloves and plastic cups on the floor and other dirt debris.<br><br>This deficient practice had a potential to attract birds, flies, insects, pest and possibly spread infection to 65 of 100 facility residents.<br><br>Findings:<br><br>During a concurrent observation of the dumpster (a large trash metal container designed to be emptied into a truck) area outside of the facility and interview with Dietary Supervisor (DS) on 9/3/2024 at 2:01 a.m., the DS stated there were cups and gloves on the ground around the dumpster area. The DS stated it was not okay to have trash around the dumpster area due to infection control. The DS stated maintenance staff is the one cleaning and maintaining the surroundings of the dumpster.<br><br>During an interview with Maintenance Supervisor (MS) on 9/4/2024 at 10:18 p.m., the MS stated the Housekeeping Supervisor (HS) was the one in charge of maintaining the dumpster area's cleanliness.<br><br>During an interview with HS on 9/4/2024 at 10:19 a.m., the HS stated they cleaned the dumpster area at a random time every day. The HS stated the trash around the dumpster area was not acceptable. The HS stated staff throwing the trash could fall and slip out of the trash. The HS stated there were too many people throwing trashes and it was hard to maintain. The HS stated it was important to maintain the dumpster area trash free due to infection control.<br><br>During a review of the facility's policies and procedures (P&P) titled Waste Control and Disposal dated 7/25/2024, the P&P indicated POLICY. All waste will be disposed of daily and as needed throughout the day. PROCEDURES (6) Outside garbage bin should be kept closed at all times and surrounding area must be kept clean.<br><br>During a review of the facility's P&P titled Maintenance and Plant Operations dated 7/25/2024, the P&P indicated Maintenance activities include:<br><br>-Providing a functional, sanitary, and comfortable environment. (l) This facility shall properly maintain the exterior of the building, the grounds, and the parking to ensure they are clean, well-kept, and free as possible of environmental pollutants. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244<br><br>Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to:<br><br>1. Ensure all staff providing resident care donned (put on) a gown for Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities) for residents with indwelling devices for one of five sampled residents (Resident 80) reviewed under the Tube Feeding (also known as enteral feeding or EF, a form of nutrition that is delivered into the digestive system as a liquid via a gastrostomy tube [GT or g-tube, a tube that is inserted into the stomach used for the administration of medication or feeding]) care area and one of one randomly observed residents (Resident 63).<br><br>2. Ensure Restorative Nurse Aide 1 (RNA 1) performed hand hygiene between providing dining assistance for two of ten residents (Resident 6 and 49) observed during the Dining task.<br><br>3. Ensure RNA 1 did not remove his mask and blow on residents food for one of ten residents (Resident 6) observed during the Dining task.<br><br>4. Ensure unlabeled, used urinal bottles were not readily available for resident use for two of six sampled residents (Resident 42 and 83) reviewed under the Infection Control task and one of one sampled residents (Resident 43) investigated under the Bladder and Bowel Incontinence care area.<br><br>5. Ensure the [NAME] suction (a protected suction tube [catheter] inside a sterile plastic sleeve) was legibly labeled with the date it was last changed for one of one sampled residents (Resident 84) reviewed under the Respiratory care area.<br><br>6. Ensure oxygen tubing was off the floor for two out of two sampled residents (Residents 84 and 87) reviewed under the Oxygen care area.<br><br>7. Ensure linen carts were protected from external contaminants by using a loosely woven/permeable (having pores or openings that permit liquids or gases to pass through) material to cover the linens.<br><br>8. Ensure residents left-hand mittens did not have light brown stains on the whole palm area for one of one randomly observed residents (Resident 63).<br><br>9. Ensure residents oxygen concentrators (a device that uses the air around you to make oxygen) were maintained clean by failing to ensure the device did not have light brown colored sticky particles and a piece of hair on top of the unit for one of one randomly observed residents (Resident 9).<br><br>Findings:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. During a review of Resident 80's Admission Record, the Admission Record indicated the facility admitted the resident on 4/3/2024 and readmitted the resident on 5/10/2024 with diagnoses that included frontal lobe (largest part of the brain) and executive function (skills used to manage everyday tasks) deficit (lack of) following nontraumatic intracerebral hemorrhage (a stroke, loss of blood flow to part of the brain which damages brain tissue), and gastrostomy (G-tube or GT, a tube placed directly into the stomach to give direct access for supplemental feeding, hydration or medicine).<br><br>During a review of Resident 80's Minimum Data Set (MDS - an assessment and care screening tool) dated 7/11/2024, the MDS indicated the resident was rarely/never able to understand others and was rarely/never able to make himself understood. The MDS indicated the resident required substantial/maximal assistance from staff for oral hygiene, toileting, bathing, and dressing, personal hygiene, and mobility.<br><br>During a review of Resident 80's Physician Orders Summary Report, the report indicated orders for the following:<br><br>-Enteral feed order, glucerna (specialized liquid medical food) 1.5 at 65 cubic centimeter (cc, a unit of measurement) per hour for 20 hours via pump (device used to delivery liquid nutrition) to provide 1300 cc / 1950 kilocalorie (Kcal, a unit of measurement of energy) per day, dated 8/27/2024.<br><br>-EBP due to presence of GT, don personal protective equipment (PPE, specialized clothing used to protect from exposure to potentially infectious materials to avoid injury or disease )/gown when providing direct patient care, every shift, dated 7/2/2024.<br><br>During a review of Resident 80's Care Plan (CP) titled, (Resident 80) is on GT feeding. At risk for . infection at GT site, initiated 5/10/2024, the CP indicated a goal to minimize the risk of feeding intolerance daily and to minimize the risk of infection and to check and maintain placement and patency of GT.<br><br>During a review of Resident 80's CP titled, Enhanced Barrier Precautions. High risk for infection feeding tubes initiated 7/2/2024, the CP indicated a goal to minimize the risk for infection by providing EBPs of gloves, gowns, and masks.<br><br>During an observation on 9/3/2024 at 12:31 p.m., Resident 80 lay in bed, observed the resident was disconnected from the EF and the EF pump was turned off. Observed LVN 3 enter Resident 80's room, don gloves, walk over to Resident 80, expose the residents GT, connect the residents GT to the EF tubing, and started the EF pump to initiate the EF. Observed LVN 3 did not don a gown prior to starting the EF. LVN 3 exited Resident 80's room.<br><br>During a follow up interview on 9/3/2024 at 12:40 p.m., LVN 3 stated Resident 80's EF starts at noon daily. LVN 3 stated he wore gloves when he accessed Resident 80's GT. LVN 3 stated he did not wear a gown when he started Resident 80's EF. LVN 3 stated the resident is on EBP because he has a GT, but LVN 3 only needed to wear a gown when he administered medication to Resident 80 via the GT. LVN 3 stated he did not need to wear a gown when starting the EF. LVN 3 stated EBPs were used for infection control during medical treatments like administering medication. LVN 3 stated starting Resident 80's EF via the GT was not a medical treatment and that was why he did not have to wear a gown.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 9/4/2024 at 1:17 p.m., the Infection Preventionist (IP) stated EBP are used to protect the residents from diseases that may be passed by the staff providing them care. The IP stated any resident with a GT would require the staff to wear gloves and a gown when accessing the device. The DON stated starting an EF is a medical treatment and the staff have been provided education to wear gloves and a gown when starting an EF.<br><br>During a concurrent interview and record review on 9/5/2024 at 1:50 p.m., the Director of Nursing (DON) reviewed the facility policy and procedure regarding EBP. The DON stated the facility policy indicates a gown must be worn when accessing the GT. The DON stated if the LVN did not wear a gown while accessing the GT, it could potentially result in the spread of infection and may cause cellulitis (spread of infection of the deep tissues of the skin and muscle).<br><br>During a review of the facility policy and procedure titled, Enhanced Barrier Precautions, last reviewed 7/25/2024, the policy and procedure indicated EBPs are utilized as an infection prevention and control intervention to prevent the spread of Multidrug-Resistant Organisms (MDROs, bacteria that have become resistant to certain antibiotics) to residents. EBPs employ targeted gown and glove use during high contact resident care activity. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include device use (feeding tube). EBPs remain in place for the duration of the resident's stay or until discontinuation of the indwelling medical device that places them at increased risk.<br><br>2.a.During a review of Resident 6's Admission Record, the Admission Record indicated the facility admitted the resident on 9/13/2021 with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), signs and symptoms concerning food and fluid intake, and muscle weakness.<br><br>During a review of Resident 6's MDS, dated [DATE], the MDS indicated the resident sometimes was able to understand others and sometimes was able to make herself understood. The MDS indicated the resident was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.<br><br>During a review of Resident 6's CP titled, (Resident 6) has alteration in nutritional status . initiated 9/13/2021, the CP indicated to have the resident up in the chair in the dining room at mealtime, to assist and give verbal cues while dining, to allow enough time to eat, to observe for chewing and swallowing difficulties, and to encourage adequate intake as tolerated.<br><br>2.b.During a review of Resident 49's Admission Record, the Admission Record indicated the facility admitted the resident on 7/21/2021 with diagnoses that included encephalopathy (a change in your brain function due to injury or disease), dysphagia (difficulty eating), dementia, and traumatic brain injury (TBI, a brain injury that is caused by an outside force).<br><br>During a review of Resident 49's MDS. dated 7/30/2024, the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make himself understood. The MDS indicated the resident was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 49's CP titled, Resident has limitation in: strength, range of motion and ability to feed himself . initiated 12/3/2021, the CP indicated to provide restorative nursing aide feeding program (RNA, certified nursing aide program that helps residents to maintain their function).<br><br>During a Dining observation on 9/3/2024 12:06 p.m., observed Resident 6 and Resident 49 sitting at a shared table in the dining room. Observed RNA 1 pull up a chair and sat between Resident 6 and 49. Observed RNA 1 pickup Resident 6's spoon of meat, RNA 1 lowered his mask, blew on Resident 6's meat, and placed the meat in Resident 6's mouth. Observed RNA 1 then put down Resident 6's spoon and pick up Resident 49's spoon and assisted the resident with feeding. RNA 1 did not perform hand hygiene between feeding Resident 6 and 49. RNA 1 continued to blow on Resident 6's food and alternate between feeding both residents at the same time until another staff member sat and continued to assist Resident 6 with feeding.<br><br>During a follow up interview on 9/3/2024 at 12:29 p.m., RNA 1 stated Resident 6's food was hot and he lowered his mask and blew on the resident's meat to cool it off. RNA 1 stated he went back and forth alternating feeding Resident 6 and 49 and did not sanitize his hands between feeding the residents. RNA 1 stated he didn't have anything to sanitize his hands with, so he did not sanitize them. RNA 1 stated he should sanitize his hands between assisting residents with feeding to prevent cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). RNA 1 stated each table should have hand sanitizer, but they do not.<br><br>During an interview on 9/4/2024 at 1:30 p.m., the IP stated he saw RNA 1 blow on Resident 6's food. The IP stated blowing on a resident's food could result in the transfer of the contaminated droplets onto the resident's food that is then ingested. The IP stated RNA 1 should not have blown on Resident 6's food. The IP stated staff should wash their hands immediately before and after providing feeding assistance to each resident.<br><br>During a concurrent interview and record review on 9/5/2024 at 1:50 p.m., the DON reviewed the facility policies and procedures regarding feeding assistance, hand hygiene, and infection control. The DON stated she was made aware that RNA 1 blew on Resident 6's food and provided feeding assistance to two residents at the same time without performing hand hygiene. The DON stated RNA 1 should never have blown on Resident 6's food because there was a risk of spreading infection from droplets that may contain organisms transferring from RNA 1's mouth to Resident 6's food. The DON stated staff must wash their hands between providing feeding assistance to residents. The DON stated the facility policy and procedures were not followed for general infection control and hand hygiene.<br><br>During a review of the facility policy and procedure titled, Infection Prevention and Control Program, last reviewed 7/25/2024, the policy and procedure indicated an infection prevention and control program is established and maintained to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>During a review of the facility policy and procedure titled, Hand Hygiene, last reviewed 7/25/2024, the policy and procedure indicated all staff members will wash their hands before and after direct resident care. Hand hygiene continues to be the primary means of preventing the transmission of infection. Situations that require hand hygiene include before and after resident contact, before and after assisting a resident with meals.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3.a. During a review of Resident 42's Admission Record, the Admission Record indicated the facility admitted the resident on 4/13/2024 with diagnoses that included encephalopathy (a change in the brain function due to injury or disease), unspecified mood disorder (mental health condition marked by disruptions in emotions [severe lows called depression or highs called hypomania or mania]), difficulty walking, muscle weakness, and acquired absence of the right leg below the knee.<br><br>During a review of Resident 42's MDS, dated [DATE], the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS indicated the resident required partial/moderate assistance from staff for toileting, dressing, personal hygiene, moving from sit to stand, transferring from the chair to bed, and toilet transfers.<br><br>3.b. During a review of Resident 83's Admission Record, the Admission Record indicated the facility admitted the resident on 5/17/2024 with diagnoses that included non-traumatic subdural hemorrhage (bleeding in the area between the brain and the skull), malignant neoplasm of parotid gland (cancer, abnormal growth in the area of the mouth that produces saliva) and malnutrition.<br><br>During a review of Resident 83's MDS dated [DATE], the MDS indicated the resident ate, dressed, and performed toileting independently.<br><br>During an observation and interview on 9/3/2024 at 9 a.m., Resident 42 sat in his wheelchair and spoke with the surveyor regarding the resident's shared restroom. Observed a used urinal hanging from the metal hand railing in the restroom. Observed the urinal was not labeled.<br><br>During a concurrent interview and observation on 9/3/2024 at 9:15 a.m., LVN 3 entered Resident 42's shared restroom and stated the urinal was not labeled and looked used. LVN 3 stated Resident 42 and Resident 83 use the shared restroom and he did not know which resident the urinal belonged to because it was not labeled. LVN 3 stated all urinals should be labeled to make sure they are used for only one resident and to prevent multiple residents from using the same urinal. LVN 3 placed the urinal in the trash.<br><br>During a concurrent observation and interview on 9/3/2024 at 9:20 a.m., Certified Nursing Assistant 10 (CNA 10) observed the unlabeled urinal in Residents 42 and 83s shared restroom. CNA 10 stated when she earlier rounded in the residents' room she did not look in the restroom and did not know there was an unlabeled urinal in there. CNA 10 stated all urinals should be labeled to identify the resident it belongs to.<br><br>During a concurrent interview and record review on 9/5/2024 at 1:50 p.m., the DON reviewed the facility policy and procedures regarding infection control and personal items. The DON stated an unlabeled urinal had the potential to be used by multiple residents. The DON stated all urinals should be labeled because they are for personal use of the resident. The DON stated if urinals are used by multiple residents there was the potential to spread infection among residents. The DON stated the facility policies and procedures were not followed.<br><br>During a review of the facility policy and procedure titled, Infection Prevention and Control Program, last reviewed 7/25/2024, the policy and procedure indicated an infection prevention and control program is established and maintained to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility policy and procedure titled, Personal Property, last reviewed 7/25/2024, the policy and procedure indicated residents' personal belongings will be identified.<br><br>During a review of the facility policy and procedure titled, Giving and Removal of Urinal, last reviewed 7/25/2024, the policy and procedure indicated to provide resident with a container for urine. Label as indicated.<br><br>44376<br><br>4. During a review of Resident 43's Admission Record, the record indicated the facility admitted the resident on 7/31/2020, and readmitted the resident on 4/5/2024, with diagnoses including chronic respiratory failure (a long-term condition that prevents the body from exchanging oxygen and carbon dioxide properly), tracheostomy, and gastrostomy (a surgical procedure used to insert a tube, often referred to as a g-tube, through the abdomen and into the stomach).<br><br>During a review of Resident 43's H&P, dated 4/5/2024, the H&P indicated the resident was bedbound with limited function.<br><br>During a review of Resident 43's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and was totally dependent on personal hygiene. The MDS also indicated the resident was incontinent of urine.<br><br>During a review of Resident 43's Order Summary Report, dated 7/31/2024, the report indicated the resident had an order for contact precautions (used for infections, diseases, or germs that are spread by touching the patient or items in the room) related to carbapenem resistant Enterobacteriaceae (CRE, a type of bacteria that are resistant to carbapenems, a class of antibiotics) every shift.<br><br>During a concurrent observation and interview on 9/6/2024, at 8:09 a.m., with Licensed Vocational Nurse 5 (LVN 5), inside Resident 43's room, observed Resident 43's two urinal bottles was not labeled with the name of the resident and the date the urinal was provided. LVN 5 stated the urinal should be labeled with the name of the resident and the date it was provided to ensure the urinals were not being interchanged with other residents and to know when to change them again to prevent infection to residents.<br><br>During an interview on 9/6/2024, at 2:01 p.m., with the DON, the DON stated the staff should label the urinal with the name of the resident, the room number, and the date when the urinal was provided to the resident to prevent interchanging bottles with other residents that can cause cross contamination and to know when to change them again.<br><br>During a review of the facility's recent policy and procedure titled, Infection Prevention and Control Program, last reviewed on 7/25/2024, the policy and procedure 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.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5.During a review of Resident 84's Admission Record, the record indicated the facility admitted the resident on 5/24/2024, with diagnoses including klebsiella pneumoniae (a common type of bacteria found in the intestines), tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow air to fill the lungs), and dependence on respirator (a mask or device worn over the mouth and nose to protect the respiratory system by filtering out dangerous substances from inhaled air) status.<br><br>During a review of Resident 84's History and Physical (H&P), dated 5/25/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 84's, dated 5/31/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognitive skills (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated the resident was on oxygen therapy, suctioning, and tracheostomy care.<br><br>During a concurrent observation and interview on 9/3/2024, at 11 a.m., with Respiratory Therapist 4 (RT 4), inside Resident 84's room, observed the [NAME] suction of the resident labeled with an unreadable date. RT 4 stated he was not able to read what date the [NAME] tubing was last changed. RT 4 stated it was important to label the [NAME] suction with a readable date to ensure the [NAME] suction was not too old as it tends to grow bacteria and viruses when used for a longer period of time that can cause the resident to get respiratory infections.<br><br>During an interview on 9/6/2024, at 2:10 p.m., with the DON, the DON stated the [NAME] suction should be labeled with the date it was last changed legibly to know when to change them again and to avoid using them for a longer period of time that can cause infection.<br><br>During a review of the facility's recent policy and procedure titled, Changing Disposable Equipment, last reviewed on 7/25/2024, the policy and procedure indicated all residents receiving respiratory care will be given a separate and complete set up. No items will be shared by residents. No disposable equipment will be recycled. Disposal equipment must be labeled with date. Friday- Ballards/T-Bar and PRN.<br><br>6.During a review of Resident 84's Admission Record, the record indicated the facility admitted the resident on 5/24/2024, with diagnoses including klebsiella pneumoniae, tracheostomy, and dependence on respirator status.<br><br>During a review of Resident 84's History and Physical (H&P), dated 5/25/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 84's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognitive skills. The MDS indicated the resident was on oxygen therapy, suctioning, and tracheostomy care.<br><br>During a concurrent observation and interview on 9/3/2024, at 11 a.m., with RT 4, inside Resident 84's room, observed Resident 84's oxygen tubing was touching the floor. RT 4 stated the oxygen tubing was touching the floor. RT 4 stated the oxygen tubing should be off the floor to prevent infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 9/6/2024, at 2:10 p.m., with the DON, the DON stated the oxygen tubing should not be touching the floor to prevent ascending infection to the resident.<br><br>During a review of the facility's recent policy and procedure titled, Infection Prevention and Control Program, last reviewed on 7/25/2024, the policy and procedure 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.<br><br>7.During a review of Resident 87's Admission Record, the record indicated the facility admitted the resident on 6/28/2024, with diagnoses including chronic obstructive pulmonary disease (COPD, a chronic lung disease that makes it difficult to breathe), esophagitis (a condition that causes the lining of the esophagus to become inflamed, swollen, or irritated), and pleural effusion (a condition where fluid builds up in the pleural space, the thin cavity between the lungs and the chest wall).<br><br>During a review of Resident 87's H&P, dated 7/2/2024, the H&P indicated the resident had the capacity to understand and make decisions.<br><br>During a review of Resident 87's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and was on oxygen therapy.<br><br>During a review of Resident 87's Order Summary Report, the report indicated an order for:<br><br>Dated 6/28/2024: Administer oxygen (O2) at (2) liters per minute (L/min, the rate at which a person receives oxygen, measured by how many liters of oxygen they inhale in a single minute) via nasal cannula (NC, a medical device that provides supplemental oxygen to patients through their nose). May titrate (to find out how much particular substance is in a liquid by measuring how much another substance is needed to react with it) up to (2-5) L/min for O2 saturation less than (86) % every shift.<br><br>Dated 6/28/2024: Change O2 tubing every night shift every Sunday.<br><br>During a concurrent observation and interview on 9/3/2024, at 11:42 a.m., with Licensed Vocational Nurse 4 (LVN 4), inside Resident 87's room, observed Resident 87's oxygen tubing was touching the floor. LVN 4 stated the oxygen tubing was touching the floor. LVN 4 stated the oxygen tubing should be off the floor to prevent infection to residents. LVN 4 stated she will change the tubing right away.<br><br>During an interview on 9/6/2024, at 2:01 p.m., with the DON, the DON stated the oxygen tubing should not be touching the floor to prevent ascending infection to the resident.<br><br>During a review of the facility's recent policy and procedure titled, Infection Prevention and Control Program, last reviewed on 7/25/2024, the policy and procedure 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.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 8.During a concurrent observation and interview on 9/6/2024, at 12:03 p.m., with Certified Nursing Assistant 3 (CNA 3), observed two linen carts near Room A covered with blue mesh, loosely woven material. CNA 3 stated the clean linens inside the carts were not being protected from environmental contaminants as the air and minute particles could pass through the cover of the carts.<br><br>During a concurrent observation and interview on 9/6/2024, at 12:06 p.m., with Registered Nurse 1 (RN 1), observed the carts near Room A was covered with loosely woven material. RN 1 stated the linens inside the carts were not protected from the environmental contaminants as it was covered by a loosely woven material mesh. RN 1 stated the material was permeable to the air and moisture that can cause bacteria and viruses to settle on the linens that can cause infections to residents.<br><br>During an interview on 9/6/2024, at 2:01 p.m., with the DON, the DON stated most of their linen carts were protected by the loosely woven mesh material and it was not protecting the clean linens inside the carts. The DON stated the contaminated linens can spread infections to residents.<br><br>During a review of the facility's recent policy and procedure titled, Laundry, and Bedding, Soiled, last reviewed on 7/25/2024, the policy and procedure indicated clean linen is protected from dust and soiling during transport and storage to ensure cleanliness.<br><br>43988<br><br>9. During a review of Resident 63's Admission Record, the Admission Record indicated the facility admitted the resident on 9/13/2022 and readmitted in the facility on 9/20/2022 with diagnoses including but not limited to chronic respiratory failure (a long term condition in which the lungs have a hard time loading the blood with oxygen and can leave a patient with low oxygen), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe] to facilitate breathing), and generalized muscle weakness.<br><br>During a review of Resident 63's History and Physical (H&P) dated 4/1/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 63's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 63 had a limb restraint.<br><br>During a review of Resident 63's Order Summary Report, the Order Summary Report indicated the following physician's orders:<br><br>oDated 5/30/2023: Right hand mitten to decrease potential injury related to episodes of pulling on life sustaining tube (informed consent obtained by physician after explanation of risks and benefits) every shift.<br><br>oDated 3/28/2024: Enhanced barrier precaution due to presence of tracheostomy and GT, don personal protective equipment /gown when providing direct patient care.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 9/4/2024 at 1:50 p.m., inside Resident 63's room with Certified Nursing Assistant 6 (CNA 6) and Certified Nursing Assistant 7 (CNA 7), observed CNA 7 wearing a mask and gloves. CNA 7 stated she was wearing a gown prior but removed it due to soiling and did not don another gown to continue providing care to the resident. CNA 7 stated Resident 63 is on EBP, and she should have donned the appropriate PPEs while providing care to the resident to protect the other residents from acquiring infection. CNA 7 stated it was an infection control issue.<br><br>During a concurrent observation and interview on 9/4/2024 at 2:00 p.m., inside Resident 63's room with Registered Nurse 1 (RN 1), RN 1 verified Resident 63's left hand mitten had light brown colored stains on the whole palm area and unable to identify the light brown discoloration. RN 1 stated it was an infection control issue.<br><br>During a review of the facility's policy and procedure titled, Infection Prevention and Control Program (IPCP), last reviewed 7/25/2024, the policy and procedure indicated an IPCP is established to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy and procedure indicated for prevention of infection, the facility educates staff and ensuring that they adhere to proper techniques and procedures.<br><br>During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precaution, last reviewed 7/25/2024, the P&P indicated EBPs are utilized to prevent the spread of multi-drug resistant organisms (MDROs - type of bacteria that resist treatment with more than one antibiotic and found mainly in hospitals and long-term care facilities). The policy indicated EMPs employ targeted gown and glove use during high contact resident care activity such as but not limited to dressing, bathing/showering, transferring, providing hygiene, and changing briefs or assisting with toileting.<br><br>10. During a review of Resident 9's Admission Record, the Admission Record indicated the facility admitted the resident on 5/4/2011 with diagnoses including but not limited to chronic respiratory failure, tracheostomy, and epilepsy (a brain condition that causes recurring seizures [abnormal electrical activity in your brain]).<br><br>During a review of Resident 9's History and Physical (H&P) dated 6/13/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 9's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living. The MDS indicated Resident 9had mechanical ventilator (a mechanical device delivers air and oxygen into the lungs of a patient whose breathing has cease[TRUNCATED] |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244<br><br>Based on interview and record review the facility failed to offer and educate about the risks and benefits of the 2023/2024 influenza vaccine (medication used to prevent a highly contagious respiratory illness, which spreads easily through the air or when people touch contaminated surfaces) for one of five sampled residents (Resident 16) reviewed during the Infection Control task.<br><br>This deficient practice had the potential to result in increased risk for residents to develop complications from influenza.<br><br>Findings:<br><br>During a review of Resident 16's Admission Record, the Admission Record indicated the facility admitted the resident on 3/18/2023 with diagnoses that included Alzheimer's disease (a type of dementia [a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), gastrostomy (GT or g-tube, a tube that is inserted into the stomach), and schizoaffective disorder (a mental health condition with symptoms of schizophrenia [delusions, hallucinations, disorganized thinking]).<br><br>During a review of Resident 16's Minimum Data Set (MDS - an assessment and care screening tool) dated 7/1/2024, the MDS indicated the resident was sometimes able to understand others and was sometimes able to make herself understood. The MDS indicated the resident was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.<br><br>During a review of Resident 16's Physician Orders, the orders indicated the following:<br><br>-[Immunization] seasonal influenza vaccine, may have flu vaccine 0.5 milliliters (mL, a unit of measurement) intramuscularly (administered in the muscle) annually (yearly) between October to March, dated 11/29/2023.<br><br>During a review of Resident 16's Care Plan (CP) titled, Risk for Infection. Resident is at moderate risk of infection secondary to .indwelling medical devices, initiated 2/18/2024, the CP indicated offer / administer vaccine if needed.<br><br>During an interview on 9/4/2024 at 1:17 p.m., the Infection Preventionist (IP) stated when a resident is admitted the facility will screen the resident for the need for any vaccinations. The IP stated vaccines are updated and administered annually. The IP stated the influenza vaccine was available for the 2023/2024 season and administered to residents that were in the facility.<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 9/5/2024 at 7:39 a.m., the IP reviewed Resident 16's Admission and clinical record and stated the resident was admitted on [DATE] and had received the 2022/2023 influenza vaccine. The IP stated Resident 16 had a conservator (a legal guardian) which made it difficult to get consent for vaccinations during the 2023/2024 vaccination season. The IP stated there was no documented evidence that the resident's responsible party was educated or provided consent or refusal for the 2023/2024 vaccine. The IP stated he could have done more and should have followed up with the resident's responsible party to ensure the vaccine was administered to the resident, but he did not. The IP stated the importance of documenting refusal of the vaccination was to show there was a conversation regarding the risk and benefits. The IP stated the importance of the vaccine was to ensure residents had a better fighting chance against the disease because vulnerable residents were the highest risk for hospitalization and death from influenza.<br><br>During an interview on 9/5/2024 at 1:50 p.m., the Director of Nursing (DON) stated vaccines are important to prevent highly dangerous diseases that affect the vulnerable population. The DON stated the facility provides education and information on vaccines in order to get residents vaccinated to protect themselves and other residents. The DON stated the facility should maintain documentation on vaccine consent or refusal that includes vaccine education regarding the risk and benefits of vaccines. The DON stated the licensed nurse that provides the consent or declination should sign and date the form and if refused then include the reason for the resident's refusal. The DON stated the facility policy was not followed for Resident 16.<br><br>During a review of the facility policy and procedure titled, Infection Prevention and Control Program, last reviewed 7/25/2024, the policy and procedure indicated an infection prevention and control program is established and maintained to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Immunization is a form of primary prevention. Widespread use of influenza vaccine in the nursing facility is strongly encouraged.<br><br>During a review of the facility policy and procedure titled, Influenza Immunization Will be Offered to all Residents Annually, last reviewed 7/25/2024, the policy and procedure indicated each resident will be offered an influenza immunization October 1 through March 31 annually unless the immunization is medically contraindicated, or the resident has already been immunized during this time period. Before offering the influenza immunization, each resident or the resident's legal representative will receive education regarding the benefits and potential side effects of the immunization. The resident or representative will have the opportunity to refuse the immunization. The medical records of the resident will include documentation that includes:<br><br>-The resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization, and<br><br>-The resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244<br><br>Based on interview and record review, the facility failed to provide education about the risks and benefits of, obtain consent or refusal for , and administer the 2023/2024 coronavirus disease 2019 vaccine (medication used to prevent complications from COVID-19 [a highly contagious viral infection that can trigger respiratory tract infection]) for three of five sampled residents (Resident 16, 43, and 46) reviewed during the Infection Control task.<br><br>This deficient practice had the potential to result in increased risk for residents to develop complications from COVID-19 including acute respiratory failure (a serious condition that occurs suddenly when the lungs cannot get enough oxygen).<br><br>Findings:<br><br>a. During a review of Resident 16's Admission Record, the Admission Record indicated the facility admitted the resident on 3/18/2023 with diagnoses that included Alzheimer's disease (a type of dementia [a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), gastrostomy (GT or g-tube, a tube that is inserted into the stomach), and schizoaffective disorder (a mental health condition with symptoms of schizophrenia [delusions, hallucinations, disorganized thinking]).<br><br>During a review of Resident 16's Minimum Data Set (MDS - an assessment and care screening tool), dated 7/1/2024, the MDS indicated the resident sometimes was able to understand others and sometimes was able to make self understood. The MDS indicated the resident was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.<br><br>During a review of Resident 16's Care Plan (CP) titled, Risk for Infection. Resident is at moderate risk of infection secondary to .indwelling medical devices, initiated on 2/18/2024, the CP indicated to offer/administer vaccine if needed.<br><br>During an interview on 9/4/2024 at 1:17 p.m., the Infection Preventionist (IP) stated when a resident is admitted the facility, they will screen the resident for the need for any vaccinations. The IP stated vaccines are updated and administered annually (yearly). The IP stated the COVID-19 booster vaccine was available for the 2023/2024 season and administered to residents that were in the facility.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 9/5/2024 at 7:39 a.m., the IP reviewed Resident 16's Admission and clinical record and stated the resident was admitted on [DATE] with no documentation that the updated 2023/2024 COVID-19 vaccine had been administered. The IP stated Resident 16 had a conservator (a legal guardian) which made it difficult to get consent for vaccinations. The IP stated there was no documented evidence that the resident's responsible party was educated or provided consent or refusal for the 2023/2024 vaccine. The IP stated he could have done more and should have followed-up with the resident's responsible party to ensure the vaccine was administered to the resident, but he did not. The IP stated the importance of documenting refusal of the vaccination was to show there was a conversation regarding the risk and benefits. The IP stated the importance of the vaccine was to ensure residents had a better fighting chance against the disease because vulnerable residents were the highest risk for hospitalization and death from COVID 19.<br><br>During an interview on 9/5/2024 at 1:50 p.m., the Director of Nursing (DON) stated vaccines are important to prevent highly dangerous diseases that affect the vulnerable population. The DON stated the facility provides education and information on vaccines in order to get residents vaccinated to protect themselves and other residents. The DON stated the facility should maintain documentation on vaccine consent or refusal that includes vaccine education regarding the risk and benefits of vaccines. The DON stated the licensed nurse that provides the consent or declination should sign and date the form and if refused then include the reason for the resident's refusal. The DON stated the facility policy was not followed for Resident 16.<br><br>During a review of the facility policy and procedure titled, COVID - 19, last reviewed 8/26/2024, the policy and procedure indicated the facility will continue to educate residents, responsible parties, and staff about the benefits of receiving the vaccination and risks of refusals. The vaccine and boosters will be offered regularly. The resident has the right to refuse COVID-19 vaccination and refusals will be documented. Appropriate documentation of the refusal will be kept. The facility will educate the resident/responsible party regarding the risk versus benefit of refusal. The facility will continue to educate the resident, responsible party regarding the benefits of COVID-19 vaccination to keep their vaccination up to date unless it is contraindicated or refused by residents.<br><br>b. During a review of Resident 43's Admission Record, the Admission Record indicated the facility admitted the resident on 10/3/2020, and readmitted the resident on 4/23/2024 with diagnoses that included sepsis (a serious condition in which the body responds improperly to an infection), chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood), tracheostomy (opening surgically created through the front of the neck and into the trachea [windpipe]), and history of COVID-19 with an onset date of 1/13/2023.<br><br>During a review of Resident 43's MDS, dated [DATE], the MDS indicated the resident was in a persistent vegetative state and the resident was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, and mobility.<br><br>During a review of Resident 43's Care Plan (CP) titled, Vaccine Refusal. Resident refused .Flu vaccine, initiated 10/2/2023, the CP indicated a goal to minimize complications from not receiving ordered vaccines through next assessment.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/4/2024 at 1:17 p.m., the Infection Preventionist (IP) stated when a resident is admitted , the facility will screen the resident for the need for any vaccinations. The IP stated vaccines are updated and administered annually. The IP stated the COVID-19 booster vaccine was available for the 2023/2024 season and administered to residents that were in the facility.<br><br>During a concurrent interview and record review on 9/5/2024 at 7:39 a.m., the IP reviewed Resident 43's Admission and clinical record and stated the resident was in the facility when the COVID-19 vaccine was administered. The IP stated the COVID-19 vaccine was not administered to the resident. The IP stated he thought the COVID-19 vaccine was declined by the resident's responsible party when the influenza vaccine was declined, but there was no documented evidence that the resident's responsible party was educated regarding the risk and benefits or provided consent or refusal for the 2023/2024 vaccine. The IP stated the importance of documenting refusal of the vaccination was to show there was a conversation regarding the risk and benefits. The IP stated the importance of the vaccine was to ensure residents had a better fighting chance against the disease because vulnerable residents were the highest risk for hospitalization and death from COVID19.<br><br>During an interview on 9/5/2024 at 1:50 p.m., the Director of Nursing (DON) stated vaccines are important to prevent highly dangerous diseases that affect the vulnerable population. The DON stated the facility provides education and information on vaccines in order to get residents vaccinated to protect themselves and other residents. The DON stated the facility should maintain documentation on vaccine consent or refusal that includes vaccine education regarding the risk and benefits of vaccines. The DON stated the licensed nurse providing the consent or declination should sign and date the form and if refused then include the reason for the resident's refusal. The DON stated the facility policy was not followed for Resident 43.<br><br>During a review of the facility policy and procedure titled, COVID - 19, last reviewed 8/26/2024, the policy and procedure indicated the facility will continue to educate residents, responsible parties, and staff about the benefits of receiving the vaccination and risks of refusals. The vaccine and boosters will be offered regularly. The resident has the right to refuse COVID-19 vaccination and refusals will be documented. Appropriate documentation of the refusal will be kept. The facility will educate the resident/responsible party regarding the risk versuss benefit of refusal. The facility will continue to educate the resident, responsible party regarding the benefits of COVID-19 vaccination to keep their vaccination up to date unless it is contraindicated or refused by residents.<br><br>c. During a review of Resident 46's Admission Record, the Admission Record indicated the facility admitted the resident on 7/31/2020 and readmitted the resident on 4/5/2024 with diagnoses that included chronic respiratory failure, tracheostomy, and history of COVID-19 with an onset date of 1/20/2021.<br><br>During a review of Resident 46's CP titled, Risk for infection. Resident is high risk for infection, initiated 8/1/2020, the CP indicated a goal to reduce the risk of infection.<br><br>During a review of Resident 46's CP titled, Vaccine Refusal. Resident refused .Flu vaccine, initiated 10/2/2023, the CP indicated a goal to minimize complications from not receiving ordered vaccines through next assessment.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 46's COVID-19 Vaccination Record Sheet, the COVID-19 Vaccination Record Sheet indicated the resident's responsible party refused administration of the COVID-19 vaccine. The vaccination sheet was undated, there was no signature or title of the staff member who provided education on the risk and benefits of the vaccine, and the sheet did not indicate a reason for the refusal.<br><br>During an interview on 9/4/2024 at 1:17 p.m., the Infection Preventionist (IP) stated when a resident is admitted , the facility will screen the resident for the need for any vaccinations. The IP stated vaccines are updated and administered annually. The IP stated the COVID-19 booster vaccine was available for the 2023/2024 season and administered to residents that were in the facility.<br><br>During a concurrent interview and record review on 9/5/2024 at 7:39 a.m., the IP reviewed Resident 46's Admission and COVID-19 Vaccination Record Sheet. The IP stated the record sheet indicated the resident representative refused the vaccine, but the form did not have a date or the signature of the staff that provided the education. The IP stated there was no documented evidence that the resident's responsible party was educated regarding the risk and benefits or provided consent or refusal for the 2023/2024 COVID-19 vaccine. The IP stated the importance of documenting refusal of the vaccination was to show there was a conversation regarding the risk and benefits. The IP stated the importance of the vaccine was to ensure residents had a better fighting chance against the disease because vulnerable residents were the highest risk for hospitalization and death from COVID-19.<br><br>During an interview on 9/5/2024 at 1:50 p.m., the Director of Nursing (DON) stated vaccines are important to prevent highly dangerous diseases that affect the vulnerable population. The DON stated the facility provides education and information on vaccines in order to get residents vaccinated to protect themselves and other residents. The DON stated the facility should maintain documentation on vaccine consent or refusal that includes vaccine education regarding the risk and benefits of vaccines. The DON stated the licensed nurse providing the consent or declination should sign and date the form and if refused then include the reason for the resident's refusal. The DON stated the facility policy was not followed for Resident 46.<br><br>During a review of the facility policy and procedure titled, COVID - 19, last reviewed 8/26/2024, the policy and procedure indicated the facility will continue to educate residents, responsible parties, and staff about the benefits of receiving the vaccination and risks of refusals. The vaccine and boosters will be offered regularly. The resident has the right to refuse COVID-19 vaccination and refusals will be documented. Appropriate documentation of the refusal will be kept. The facility will educate the resident/responsible party regarding the risk versus benefit of refusal. The facility will continue to educate the resident, responsible party regarding the benefits of COVID-19 vaccination to keep their vaccination up to date unless it is contraindicated or refused by residents. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>43418<br><br>Based on observation, interview, and record review, the facility failed to ensure residents were provided a functioning call light system (device used to summon facility staff) for one of 11 sampled residents (Resident 70) when Resident 70's call light did not activate alert light outside Resident 70's doorway after the resident activated the call light.<br><br>This deficient had the potential for Resident 70 to be unable to summon staff and cause a delay in provision of care.<br><br>Findings:<br><br>During a review of Resident 70's Admission Record, the Admission Record indicated the facility originally admitted Resident 70 on 8/30/2023 and readmitted the resident on 6/8/2024 with diagnoses including difficulty in walking and generalized muscle weakness.<br><br>During a review of Resident 70's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/15/2024, the MDS indicated Resident 70 was able to understand and make decisions, was independent with eating, and required maximal assistance or is dependent on staff for activities of daily living including, toileting, hygiene, dressing, and surface-to-surface transfers.<br><br>During a review of Resident 70's History and Physical (H&P), dated 8/31/2024, the H&P indicated Resident 70 had fluctuating capacity to understand and make decisions.<br><br>During a review of Resident 70's Care Plans, dated 7/2/2024, the care plan indicated Resident 70 was at risk for unavoidable decline related to generalized weakness with interventions including keeping the call light within reach, and attending to needs promptly.<br><br>During a concurrent observation and interview with Resident 70, on 9/3/2024, at 1:45 p.m., inside Resident 70's room, Resident 70 pressed the button on his call light and the activation light outside of his room was not lit up. Resident 70 stated he had concerns that his call light was not working most of the time and had experienced a delayed response of up to two hours.<br><br>During a concurrent observation and interview with Certified Nursing Assistant (CNA) 5, on 9/3/2024, at 1:51 p.m., inside Resident 70's room, CNA 5 pressed the button on Resident 70's call light and confirmed the call light was working from the call light deactivation button located inside the resident's room. CNA 5 checked the outside of the room and confirmed that the activation light outside Resident 70's room did not turn on after pressing the button on Resident 70's call light. CNA 5 further stated that Resident 70's call light may be broken.<br><br>During an interview with the Director of Nursing (DON), on 9/6/2024, at 2:01 p.m., the DON stated it is important that the residents' call light system is working properly because the facility staff would not be able to meet the needs of the resident. The DON further stated depending on the situation, there is a potential that the resident could be in distress, can affect the resident's dignity and safety, and if there was an emergency, the facility staff would not be aware and check on the resident.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's policy and procedure (P&P) titled, Call Lights, last reviewed 7/25/2024, the P&P indicated monitoring the lights and making sure that the lights are answered promptly, regardless of who is assigned to each resident. The P&P further indicated all staff shall know how to place the call light for a resident and how to use the call light system .<br><br>During a review of the facility's P&P titled, Maintenance and Plant Operations, last reviewed 7/25/2024, the P&P indicated maintenance activities include ensuring that all equipment, buildings, spaces, and fixtures are kept in operable condition. |