

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2024
NAME OF PROVIDER OR SUPPLIER Glenoaks Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 409 W. Glenoaks Blvd. Glendale, CA 91202	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48481</p> <p>Based on observation, interviews, and record reviews the facility failed to ensure one of the 18 sampled residents (Resident 48) received his meal tray at the same time with other residents that were sitting in the same table. It was not until 20 minutes later Resident 48 received his meal tray and was eating by himself.</p> <p>This deficient practice violated the rights of Resident 48 to have dignified, equal care and potentially cause emotional distress, loss of appetite, and further affect or damaged to (his, her) health condition.</p> <p>Findings:</p> <p>During an observation on 12/3/24 at 12:15 PM in Activity/Dining Room, Resident 48 was observed sitting in the dining room waiting for the lunch tray while other residents at the same table were eating.</p> <p>During a review of Resident 48 's Admission Record, indicated Resident 48 was admitted on [DATE] with diagnoses that include but not limited to Gastroesophageal Reflux Disease (GERD- a condition in which the stomach contents leak backward from the stomach into the esophagus (food pipe)), and dysphagia (difficulty swallowing).</p> <p>During the same dining observation on 12/3/24 at 12:30 PM Resident 48 received his lunch tray. Resident 48 stated he waited extra 20 minutes before he received his lunch tray.</p> <p>During an interview with Resident 48 on 12/3/24 at 12:31 PM in the dining room, the resident stated I ' m the last, I always have to wait. I feel hurt.</p> <p>During an interview on 12/3/24 at 1:01 PM with the Activity Director (AD) in the dining room, the AD stated not aware that Resident 48 received lunch tray late and not sure why Resident 48 had to wait longer than 15 minutes for his lunch while other residents at the same table were eating. AD stated staffs would check trays first and deliver at the same time.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/4/24 10:40 AM with the Dietary Supervisor (DS) in the kitchen, the DS stated there are four carts total, divided by room numbers in general, from 1 to 47, the cart sequence for delivery is when the trays are completely prepared, room [ROOM NUMBER] to 11 are prepared first so sent out first, around 12 PM. The AD gives the list of residents that go to dining room for their meals and the carts will stop in front of dining room before it goes to the nursing stations. If there is a special request for early tray, that tray will be pulled out, prepared, and delivered to the resident once ready.</p> <p>During an interview on 12/6/24 at 10:00 AM with the Registered Dietitian (RD) on the phone, the RD stated it was not acceptable for some residents to wait longer than 2-5 minutes before receiving their meals while others were eating. RD also stated that residents who eat in the dining room should all be served at the same time regardless of residents are on the list or not.</p> <p>During a review of facility ' s policy and procedure titled, Meal Service dated 2023, indicated that all residents at the same table should be served at the same time.</p> <p>During a review of facility ' s policy and procedure titled, Privacy and Dignity dated 6/1/17, indicated that the facility promotes independence and dignity in dining.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>36925</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the call light (a system that alerts the nursing home staff to the needs of a resident) for 2 of two sampled residents (Resident 45 and Resident 46) who were lying in bed was within reach.</p> <p>This deficient practice had the potential to increase the resident ' s risk of falls, heighten the resident ' s anxiety (fear of the unknown) from not being able to easily call for help, and worsen the resident ' s medical condition due to delayed care.</p> <p>Findings:</p> <p>1. A review of Resident 45 ' s Admission Record indicated that the facility admitted the resident on 8/3/2021 and readmitted the resident on 3/7/2024 with diagnoses that included depression (a common mental health condition that can impact a person's thoughts, feelings, behavior, and sense of well-being).</p> <p>A review of Resident 45 ' s Minimum Data Set (MDS - a resident assessment tool), dated 11/4/2024, indicated that the resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired and that the resident was dependent (helper does all of the effort and the assistance of 2 or more helpers are required for the resident to complete the activity) on a helper to perform daily living activities including but not limited to eating, toileting, and personal hygiene.</p> <p>A review of Resident 45 ' s plan of care that was created on 11/13/2024 indicated that the resident will be free of falls by ensuring that the resident ' s call light is within reach and encouraging the resident to use it for assistance as needed.</p> <p>During an observation on 12/3/2024 at 9:31 AM, the call light of Resident 45 was observed hanging on her bedside and was not within her reach. During a concurrent interview with Licensed Vocational Nurse (LVN) 3, she stated that the call light must be within the resident ' s reach to enable the resident to call for assistance when needed.</p> <p>During an interview on 12/3/2024 at 4:10 PM, LVN 1 stated that the Certified Nurse Assistant (CNA) is responsible for ensuring that the call light is within the resident ' s reach.</p> <p>During a concurrent interview with CNA 2, she stated that the call light of the resident frequently falls from the bed because the resident moves a lot; however, she stated that the CNA was responsible for ensuring that the call light was within the resident ' s reach.</p> <p>During an interview on 12/5/2024 at 2:41 PM, the Director of Nursing (DON) stated that the purpose of the call light is to enable the resident to call for assistance when needed. The DON stated if the resident does not have a working call light or is not within reach, the resident has the potential to be exposed to harm by not being able to alert the nursing staff when help is needed. The DON stated that it was the responsibility of all the nursing staff to ensure that the call light is within the reach of the resident after they provide bedside care or when they do their rounds.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>50012</p> <p>2. During a review of Resident 46 ' s Admission Record (Face Sheet), dated 12/4/2024, the face sheet indicated the facility admitted Resident 46 on 12/ 4/2022, with diagnoses including Alzheimer's disease (progressive mental deterioration), and diabetes mellitus (DM: long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin).</p> <p>During a review of Resident 46 ' s History and Physical (H&P), dated 7/18/2024 indicated, Resident 46 does not have the mental capacity to make medical decisions.</p> <p>During a review of Resident 46's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/23/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and needed supervision to extensive assistance from the staff for the activities of daily living.</p> <p>During a review of Resident 46's plan of care regarding risk for fall and/or injury-initiated 4/4/2024, indicated the resident will be free from fall or injury. The care plan interventions included the call light was to be placed within reach and answered promptly.</p> <p>During an observation on 12/3/2024, at 11:18 AM in Resident ' s 46 room, Resident 46 was observed seated in a Geriatric chair with a lap table. The call light was observed not within the resident's reach, leaving the resident unable to call for assistance if needed.</p> <p>During a concurrent observation and interview on 12/3/2024 at 12:28 PM with Certified Nurse Assistant 1 (CNA 1) in Resident 46 ' s room, CNA 1 stated that the resident is unable to get up or use the call light because the resident is seated in a Geriatric chair with a lap table, which the resident is unable to remove on her own. The CNA 1 further stated that this setup restricts the resident ' s movement and leaves her feeling stuck. CNA 1 stated the call light should be placed where the resident can reach it at all times.</p> <p>During an interview on 12/3/2024 at 12:35 PM with the License Vocational Nurse 2 (LVN 2), the LVN 2 stated Resident 46 occasionally uses the call light, but emphasized the importance of ensuring it is placed within closer reach. This will allow the resident to easily access it for assistance or in the event of a fall; otherwise, she may resort to yelling for help.</p> <p>A review of the facility's undated policy titled, Communication - Call System version 2.0, revised on 10/24/2022 indicated that the facility will provide a call system to enable the residents to alert the nursing staff from their beds when help is needed and would place the call cords within the resident's reach in the resident's room.</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203</p> <p>Based on observation, interview, and record review, the facility failed to ensure three of three sampled residents (Resident 19, 1, and 20) had that their medical records updated to show documentations that:</p> <ol style="list-style-type: none"> 1. Resident 19, Resident 20, or their Responsible Party (RP) were offered and explained on how to execute an Advance Directive (a written statement of a person 's wishes regarding medical treatment made to ensure those wishes were carried out should the resident be unable to communicate them to the doctor). 2. Resident 1 and 20 ' s had a Physician Order Life Treatment (POLST, a portable medical order form that records the resident ' s treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency) had a physician ' s signature. <p>These failures had the potential to cause conflict with the resident ' s wishes regarding the alternatives in the provision of health care and the failure to convert the resident ' s wishes regarding life-sustaining treatment and resuscitation (the act of reviving someone who has stopped breathing or is unconscious) into physician orders.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 19 ' s Admission Record, the facility admitted Resident 19 on 12/16/2014 and readmitted Resident 19 on 5/20/2020 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, a chronic lung disease causing difficulty in breathing), parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), and muscle weakness. <p>During a review of Resident 19 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the resident ' s health status), dated 10/10/2023, the H&P indicated Resident 19 had the capacity to understand and make decisions.</p> <p>During a review of Resident 19 ' s Advance Directive Acknowledgement form, dated 7/6/2024, there was no documented evidence whether the option of an advance directive was informed or offered to Resident 19 and their RP.</p> <p>During a review of Resident 19 ' s Minimum Data Set (MDS, a resident assessment tool), dated 9/29/2024, the MDS indicated that Resident 19 was moderately cognitively (a person ' s mental process of thinking, learning, remembering, and using judgement) impaired. The MDS indicated Resident 19 required substantial to dependent assistant for all ADLs.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of Resident 20 ' s Admission Record, the facility admitted Resident 20 on 10/25/2024 and readmitted Resident 20 on 11/18/2024 with diagnoses that included a displaced intertrochanteric fracture of the right femur (fracture of the right upper thigh bone), cellulitis (a bacterial skin infection) of the right lower limb, and paranoid schizophrenia (a mental illness where someone experiences intense paranoia characterized by hallucinations [perceptual experiences in the absence of real external sensory stimuli] and delusions [misconceptions or beliefs that were firmly held, contrary to reality]).</p> <p>During a review of Resident 20 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 10/26/2024, the H&P indicated that Resident 20 had the ability to make her needs known but does not have the capacity to consent.</p> <p>During a review of Resident 20 ' s MDS, dated [DATE], the MDS indicated Resident 20 ' s cognitive status was severely impaired. The MDS indicated Resident 20 was dependent on all ADLs and required substantial assistance when moving from sitting on the side of the bed to lying down and when turning side to side in bed. The MDS indicated Resident 20 did not hallucinate or have delusions.</p> <p>During a review of Resident 20 ' s POLST form, dated 10/26/2024, the POLST did not have a physician ' s signature.</p> <p>During a review of Resident 20 ' s Advance Directive Acknowledgement form, dated 10/26/2024, there was no documented evidence whether the option of an advance directive was informed or offered to Resident 20 and her RP.</p> <p>3. During a review of Resident 1 ' s Admission Record, the facility admitted Resident 1 on 11/17/2023 and readmitted Resident 1 on 9/7/2024 with diagnoses that included muscle wasting and atrophy (wasting away of muscle mass), unspecified dementia (a progressive state of decline in mental abilities), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) malfunction.</p> <p>During a review of Resident 1 ' s H&P, dated 9/10/2024, the H&P indicated Resident 1 did not have the capacity to understand or make decisions.</p> <p>During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated that Resident 1 rarely or never made any daily decision makings. The MDS indicated that Resident 1 was dependent (a helper does all the effort or required the assistance of two or more helpers to complete the activity) for all activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily). The MDS indicated that Resident 1 required substantial assistance (helper does more than half the effort) when turning side to side in bed and from sitting to lying in bed.</p> <p>During a review of Resident 1 ' s POLST form, dated 3/27/2024, Physician ' s 1 ' s signature was not documented.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent record review and interview on 12/4/2024 at 2:03PM with Registered Nurse (RN) 1, Resident 1, 19, and 20 's POLST and advance directive were reviewed. RN 1 stated, Resident 1 ' s POLST was not signed by the Physician 1. RN 1 stated, Resident 19 ' s advance directive was not filled out completely and did not indicate whether the advance directive was explained to Resident 19 ' s RP. RN 1 stated, Resident 20 ' s POLST was not signed by the physician (unable to identify) and the advance directive was not filled out completely and did not indicate whether the advance directive was explained to Resident 19 ' s RP. RN 1 stated, nursing initiated and completed the POLST upon admission, and the Social Services Director (SSD) follows up on the POLST the following day. RN 1 stated, the SSD reviews the POLST to ensure it was filled out, which included making sure a physician ' s signature was present. RN 1 stated, if the POLST was missing a physician ' s signature, the physician had 72 hours to come in the facility to sign the POLST. RN 1 stated, the POLST was a set list of physician ' s orders that required a physician ' s signature because it was important that the physician confirms that all the orders on the POLST were correct. RN 1 stated, the advance directive should be filled out to ensure the advance directive was thoroughly explained to the resident or the RP. RN 1 stated, if there was an advance directive, the advance directive should be followed because it was the resident ' s wishes in case of an emergency.</p> <p>During a concurrent record review and interview on 12/4/2024 at 2:35PM with the SSD, Resident 1, 19, and 20 ' s POLST and advance directive were reviewed. The SSD stated, she forgot to check the POLST and advance directive for completeness. The SSD stated, it was her responsibility to ensure the POLST and advance directive were explained to the resident and resident ' s RP and ensure the forms were filled out completely. The SSD stated, she and the Director of Nursing (DON) reviewed all POLST and advance directive forms to ensure completion, which included checking for physician and RP signatures. The SSD stated, the Medical Records Director (MRD), conducted a third audit to ensure the POLST and advance directive were filled out completely before uploading into the resident ' s medical chart. The SSD stated, the physician ' s signature should be on the POLST in 1-2 days upon admission because the physician needs to agree to the POLST. The SSD stated, it was important to explain what an advance directive was and what options the resident or resident ' s RP had.</p> <p>During a concurrent record review and interview on 12/4/2024 at 2:35PM with the MRD, Resident 1, 19, and 20 ' s POLST and advance directive were reviewed. The MRD stated, she audited the resident ' s medical records, which included checking that all sections of the POLST and advance directive. The MRD stated, she did not check Resident 1, 19, and 20 ' s POLST and advance directive for completeness. The MRD stated, if there was an incomplete section or a signature missing on the POLST or advance directive, she should have followed up with the SSD and with the physician.</p> <p>During a review of the facility ' s policies and procedures (P&P), Physician Orders for Life Sustaining Treatment (POLST), dated 6/1/2017, the P&P indicated a completed and signed POLST form is a legal physician order that was immediately actionable. The P&P indicated the physician will review the order after admission and consult with the resident to ensure that the order was consistent with the resident ' s goals. The P&P indicated that a licensed nurse or Social Services Designee will explain the POLST form to the resident or the resident ' s responsible party and will notify the physician, nurse practitioner or physician assistant.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility ' s P&P, Advance Directives, revised on 6/1/2021, the P&P indicated, the facility will inform the resident of their right to execute an Advance Directive Form, if one does not already exist. The P&P indicated, if a resident does not have the capacity to understand the information about an advance directive, the facility may give advance directive information to the resident ' s representative in accordance with state law. The P&P indicated, each resident is informed of their choice to complete the advance directive, and the choice not to complete the advance directive Form is recorded in the resident ' s medical record.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467</p> <p>Based on observation, interview, and record review, the facility failed to follow and implement the facility ' s Policies and Procedures (P&P) titled, Change of Condition Notification, revised [DATE], for one of three sampled residents (Resident 77) with diagnoses of chronic obstructive pulmonary disease exacerbation (COPD, worsened and severe symptoms of a lung disease characterized by poor airflow to the lungs that results in shortness of breath, and respiratory distress (a condition that occurs when the body needs more oxygen than it's getting, leading to difficulty breathing, rapid breathing, and low blood oxygen levels) and a history of pneumonia (a severe respiratory infection that results in shortness of breath and difficulty breathing) by failing to:</p> <ol style="list-style-type: none"> 1. Ensure to notify the physician and 911 (an emergency number) emergency services immediately, when Resident 77 complained of not being able to breath and exhibited signs and symptoms of respiratory distress, labored breathing (take more efforts to breath) and oxygen saturation of 72% (normal range 90 to 100 percent) on [DATE] at 12:10 AM. 2. Ensure the physician was informed that Resident 77 was refusing to go to the hospital while complaining of not being able to breath and exhibited signs and symptoms of respiratory distress, labored breathing, and oxygen saturation of 72% on [DATE] at 12:10 AM. <p>As a result of these deficient practices Resident 77 did not receive immediate respiratory care and interventions on [DATE] from 11:06 PM when the resident was initially observed with respiratory distress, labored breathing, decreased level of oxygenation, until [DATE] at 2:29 AM when the paramedics pronounced Resident 77 dead after unsuccessful CPR (cardiopulmonary resuscitation, an emergency treatment for someone who stopped breathing or heartbeat has stopped by providing chest compression [pressing on the chest over the heart] and rescue breathing [mouth-to-mouth resuscitation]) was provided.</p> <p>Cross reference to F695 and F867</p> <p>Findings:</p> <p>During a review of Resident 77's Admission Record (AR), the AR indicated the facility admitted Resident 77 on [DATE] and readmitted on [DATE] with diagnoses that included COPD with exacerbation (worsened symptoms), pneumonia, hypertensive heart disease (high blood pressure), and type 2 diabetes mellitus (condition of having high blood sugar).</p> <p>During a review of Resident 77 ' s Physician Orders for Life-Sustaining Treatment (POLST- a medical order that documents a patient's preferences for end-of-life care), dated [DATE], indicated if the resident was found with a pulse and/or was breathing, full treatment was ordered for medical interventions including intubation (a tube placed in the mouth to the airway to provide oxygenation), advanced airway interventions (a tube place in the airway), mechanical ventilation (assisted breathing provided with the use of a machine), and cardioversion (a medical procedure that restores a normal heart rhythm by using electricity or medication to treat an abnormal heart rhythm).</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 77 ' s Order Summary Report (OSR), indicated on [DATE], Resident 77 had physician orders to monitor for sign and symptoms of respiratory distress that included monitoring for pulse oximetry (a device used to monitor oxygen blood level), lethargy (a state of unusual drowsiness, fatigue, and lack of energy and mental alertness), accessory muscle usage (breathing using muscles other than those typically used for breathing to take in and expel air) and to document with hashmarks (or tally marks, a numerical system used to keep track of things by number) in the clinical record of the resident if present and report to the physician. The physician also ordered to titrate (adjust) oxygen at ,d+[DATE] L/min via NC continuously to maintain oxygen saturation at 92 % or above, and to notify the physician if oxygen saturation was below 92% for SOB. The OSR indicated in the event of an emergency, the Medical Director may be called if the attending physician or alternate physician are not available.</p> <p>During a review of Resident 77 ' s History and Physical Examinations, dated [DATE], indicated Resident 77 had the capacity to understand and make decisions.</p> <p>During a review of Resident 77 ' s OSR, indicated on [DATE], Resident 77 had a physician order for Full Code [a medical order that instructs the health care team to perform all possible life-saving measures if the resident goes into cardiac or respiratory arrest (when the heart stopped beating or the resident stopped breathing)].</p> <p>During a review of Resident 77 ' s Physician Progress Note, dated [DATE], indicated Resident 77 exhibited alertness and cognitive ability to effectively communicate needs and his language comprehension and response during assessments were appropriate. The notes indicated Resident 77 continued under monitoring for anemia (a condition of not having enough healthy red blood cells to carry oxygen to the body's tissues) and has declined hospitalization despite the recommendation, understanding the associated risks and benefits.</p> <p>During a review of Resident 77 ' s Physician Progress Note, dated [DATE], indicated when confronted with acute medical symptoms or conditions necessitating immediate attention for Resident 77, the staff has received explicit instructions to promptly trigger emergency medical services (EMS) via 911 and direct the resident to the emergency department. These symptoms and conditions encompass, though are not confined to exacerbation (severe symptoms) of asthma (a respiratory disorder that makes it difficult to breath). The note indicated, the data mentioned above is based on information available during the encounter and may change as other data becomes available.</p> <p>During a review of Resident 77 ' s Progress Notes, dated [DATE], indicated on [DATE] at 11:05 PM, during an initial assessment Licensed Vocational Nurse (LVN) 6 noted Resident 77 was in bed asleep but responsive to verbal stimuli with no complaint of pain or discomfort. The note indicated on [DATE] at 12:10 AM, Resident 77 was sitting on his bed and verbalized I can ' t breathe, I need a breathing treatment, breathing was labored with oxygen saturation was at 72%. The note indicated LVN 6 administered a breathing treatment and offered to transfer the resident to the hospital of which Resident 77 declined and on [DATE] at 12:30 AM, Resident 77 verbalized thank you, I ' m feeling better. The note indicated at on [DATE] at 1 AM, Resident 77 was asleep with eyes closed and receiving continuous oxygen at 2 L/min, then at 1:55 AM, LVN 6 was alerted to Resident 77 ' s room by Certified Nurse Assistant (CNA) 4, that Resident 77 was unresponsive with no chest movement and no pulse, CPR was initiated and 911 was called. The notes indicated on [DATE] at 2:10 AM, the paramedics arrived and took over the CPR and Resident 77 was pronounced dead at 2:29 AM and Resident 77 ' s physician was notified via text on [DATE] at 3:16 AM.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 77 ' s Physician ' s Discharge Summary, dated [DATE], indicated Resident 77 was discharged from the facility due to resident expired.</p> <p>During a review of Paramedic Run Report, dated [DATE], indicated Resident 77 presented warm, pupils were fixed (indication of no brain activity), in asystole (no heart rhythm) and for the duration of CPR. The report indicated, Resident 77 remained in asystole with no changes after given 3 Epinephrine (the primary drug administered during CPR to reverse cardiac arrest) doses and was pronounced dead at 2:29 AM after 20 minutes of high-quality CPR. The report indicated, staff stated the patient Resident 77) is being seen at this facility for COPD and possible pneumonia. Pt was advised to go to the hospital by staff numerous times for better care and treatment but declined for a week. Pt was given a breathing treatment by staff at midnight with no improvement and was found not breathing at around on [DATE] at 2 AM. Staff immediately began CPR and called 911. CPR taken over by EMS on [DATE] at 2:09 AM.</p> <p>During an interview on [DATE] at 4:37 PM with CNA 4, CNA 4 stated, when she came to work on [DATE] at around 11:06 PM, Resident 77 did not respond when she tried to greet him, his eyes were closed, and he was breathing very fast. CNA 4 stated, Resident 77 was receiving oxygen supplement with a tube in his nose. CNA 4 stated, LVN 6 told her that Resident 77 was not feeling well and that she should keep an eye on the resident. CNA 4 stated, she checked Resident 77 several times and observed Resident 77 ' s breathing was getting loose and loose to the point of no breathing anymore, and his facial expression was flat. CNA 4 stated, she asked LVN 6 to Please come and check on Resident 77 because she had to attend another resident. CNA 4 stated, LVN 6 went to see Resident 77 and she went to another resident's room to give care. CNA 4 stated, when she came out of the other resident's room, she saw LVN 4 bringing in a big oxygen tank to Resident 77 ' s room. CNA 4 stated, when she looked into Resident 77 ' s room, LVN 4 told her that the resident was dead. CNA 4 stated, she recalled LVN 4 was performing CPR on Resident 77, but she did not come to help in Resident 77 ' s room because she was busy with the other resident.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 5:09 PM with LVN 6, LVN 6 stated, when he first checked on Resident 77 at the start of his shift on [DATE] at around 11 PM, Resident 77 ' s vital signs including the oxygen saturation was around ,d+[DATE]% while Resident 77 was receiving 2 L/min oxygen via NC. LVN 6 stated, Resident 77 was breathing heavily, and very labored. LVN 6 stated, about an hour later, Resident 77 told him I can ' t breathe, I want my breathing treatment. LVN 6 stated he checked Resident 77 ' s oxygen saturation and it was at 72%. LVN 6 stated, he asked Resident 77 if he wanted to be transferred to the hospital, but Resident 77 stated No, meaning he didn't want to go the hospital, so LVN 6 gave Resident 77 Albuterol breathing treatment as ordered by the physician. LVN 6 stated, after the treatment, Resident 77 ' s oxygen saturation went up, but not that high, to ,d+[DATE]%. LVN 6 stated, he asked Resident 77 again if Resident 77 wanted to be transferred to the hospital, Resident 77 stated No. LVN 6 stated, after the breathing treatment was given, he put Resident 77 back to continuous oxygen at 3 L/min via NC. LVN 6 stated, he did not recheck Resident 77 ' s vital signs when Resident 77 had an episode of decreased oxygen saturation of 72%, and he did not recheck and monitor Resident 77 ' s oxygen saturation after giving Resident 77 ' s breathing treatment when the oxygen saturation increased to ,d+[DATE]%. LVN 6 stated, when communicating with the physicians at the facility, the staffs only text the doctors during the night, the staffs do not call the doctors if they need to report the resident ' s condition. LVN 6 stated, he did not document Resident 77 ' s COC, notify the doctor via text or call, or call 911 regarding Resident 77 ' s labored breathing, low oxygen level, changes in the respiratory and refusal to go to the hospital because Resident 77 had a behavior of refusing to be transferred to the hospital and because LVN 6 believed that Resident 77 ' s breathing was better given that the oxygen saturation went up from 72 % to ,d+[DATE]%. LVN 6 also stated, he was busy with other residents. LVN 6 stated, he told CNA 4 to keep an eye on Resident 77 for his movement in case Resident 77 was not breathing. LVN 6 stated, when CNA 4 came and told him to come to see Resident 77, he rushed in Resident 77 ' s room, tapped on Resident 77 ' s shoulder but the resident was not responding. LVN 6 stated, Resident 77 ' s chest was not moving up and down, so he ran out of the room to call for help and brought in the bigger oxygen tank. LVN 6 stated, LVN 7 was helping him to call 911 while he went back to Resident 77 ' s room and started CPR. LVN 6 stated, the resident ' s room did not have any button to activate Code Blue. LVN 6 stated, he did not call for a Code Blude overhead because he did not want to panic other residents during the nighttime.</p> <p>During a concurrent record review and interview on [DATE] at 9:14 AM with the Regional Medical Record (RMR), Resident 77 ' s Change of Condition/MD notification and orders for the month of [DATE] were reviewed. The RMR stated, there was no documented evidence that a COC was completed, no indication that the physician was notified, and no physician order to address Resident 77 ' s respiratory distress and decreased oxygenation on [DATE]. The RMR stated, there was no care plan for Resident 77 ' s refusal to go to the hospital and no documented evidence that alternative interventions were discussed with Resident 77 regarding his refusal. There was also no documentation that the DON, Administrator or the facility ' s Medical Director was informed about Resident 77 ' s change in respiratory condition.</p> <p>During an interview on [DATE] at 10:04 AM with the MDS Nurse (MDSN), the MDSN stated, when Resident 77 desaturated (a drop in blood oxygen level) and was having SOB, LVN 6 should follow the doctor ' s order to notify the doctor right away about the situation and the resident's low saturation even when the resident refused to be transferred to the hospital. The MDSN stated, the doctor should be notified about the resident ' s refusal because if the resident was alert enough, the doctor could explain to the resident that if he refused care, it could lead to death. The MDSN stated, it was important to notify the doctor right away so the LVN could have orders for immediate interventions and treatment. The MDSN stated, the doctor might also ask the nurse to just call 911.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 11:16 AM with the Director of Nurses (DON), the DON stated, at nighttime, the facility doesn't have any registered nurse, only LVNs. The DON stated, depending on the severity of the situation, the doctor could be contacted via calls or text messages. The DON stated, if the primary physician didn't respond, the medical director could be notified. The DON stated, he was also available ,d+[DATE] in case of emergency for guidance. The DON stated, in a situation when the resident's saturation went down to 72% and was having SOB and there was order for breathing treatment, the nurse could send the doctor a text to notify the doctor about the situation. The DON stated, while waiting for the doctor ' s response, the LVN should monitor for the resident ' s vital signs including oxygen saturation, put the resident on oxygen and titrate to the max oxygen level as ordered, give breathing treatment and continue to monitor the resident for how the resident was doing with vital signs and document them in the resident ' s medical record. The DON stated, if the oxygen saturation was at ,d+[DATE]% after treatment, the treatment was not effective. The DON stated, if the resident refused to be transferred to the hospital, the nurse should notify the doctor right away to report the situation that the oxygen and breathing treatment was given as ordered but the oxygen saturation level did not increase as expected and that the resident refused transferring to the hospital. The DON stated, LVN 6 should have reported Resident 77 ' s desaturation episode and his refusal to the doctor even if LVN 6 respected Resident 77 ' s right and have the doctor decide what to do. The DON stated, 911 should have been called to manage the situation.</p> <p>During an interview on [DATE] at 4:50 PM with Resident 77 ' s primary physician (PMP 1), the PMP 1 stated, on the night of [DATE], he did not receive any text or call from the facility staff regarding Resident 77 ' s desaturation and SOB. PMP 1 stated, he only got a text to notify him that his patient (Resident 77) had passed away early morning of [DATE] because of unresponsiveness and not breathing. PMP 1 stated, when the oxygen saturation went down to 72% and Resident 77 was having SOB, LVN 6 should give breathing treatment and notify him at least via text messages. PMP 1 stated, after breathing treatment, when the oxygen saturation went up to ,d+[DATE]%, the saturation was still too low, and Resident 77 should have been transferred out to the hospital for higher level of care. PMP 1 stated, even when Resident 77 refused, LVN 6 should have let him know. PMP 1 stated, he would have asked LVN 6 to transfer or call 911. PMP 1 stated, their practice is very aggressive with transferring out in cases of emergency that the patient was not able to be stabilized. PMP 1 stated, if he was aware of the patient's repeated refusal to care, he would consider hospice or discuss with him of changing in code status if Resident 77 was alert able to decide for himself. PMP 1 stated, LVN 6 should not decide by himself without informing the physician whether to not transfer Resident 77 to the hospital or not due to respecting the resident ' s right because Resident 77 was still a full code.</p> <p>During a review of the facility ' s Policies and Procedures (P&P) titled, Change of Condition Notification, revised [DATE], indicated the following:</p> <p>a. An acute COC is a sudden, clinically important deviation from a patient ' s baseline in physical, cognitive, behavioral, or functional domains. Clinical important means a deviation that, without intervention, may result in complications or death.</p> <p>b. The Licensed nurse will notify the resident ' s Attending Physician when there is a significant change in the resident's physical, mental or psychosocial status, e.g., deterioration in health, life threatening conditions or clinical complications; a need to alter treatment signification; and a decision to transfer or discharge the resident from the facility.</p> <p>c. The Licensed Nurse will assess the resident's COC and document the observations and symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. The Attending Physician will be notified timely with the residents ' COC. Notification to the Attending Physician will include a summary of the condition change, and an assessment of the resident ' s vital signs.</p> <p>e. In emergency situations (e.g., a resident is experiencing unexpected SOB), the Licensed Nurse will: immediately call the Attending Physician.</p> <p>f. If the Licensed Nurse is unable to reach the Attending Physician or the Physician on call during emergency situations, he/she will notify the Facility ' s Medical Director. If the resident deteriorates, the symptoms are serious, and the most rapid intervention available by a physician would place the resident in great jeopardy, call 911 for transport to hospital.</p> <p>g. Notify the Nursing Supervisor of emergency situation.</p> <p>During a review of the facility ' s P&P titled, Emergency Care - General, revised [DATE], indicated, emergency - Life threatening is the situation that requires prompt intervening actions to maintain physical, mental, and/or emotional health. Summon help and immediately call 911 for medical emergency assistance. These emergency situations would include but are not limited to: cessation (stop) of breathing and document the resident ' s vital signs including blood pressure, pulse, respirations and temperature.</p> <p>During a review of the facility ' s P&P titled, Pulse Oximetry (Assessing Oxygen Saturation), revised [DATE], indicated:</p> <p>a. A normal oxygen saturation is between 90 to 100 percent. Anything below 90 percent should be closely monitored, including the maintenance of a flow chart or documentation record for oxygen saturation level.</p> <p>b. If oxygen saturation is less than 90 percent, if oxygen saturation is at less than an acceptable level for the resident ' s condition, notify the Attending Physician.</p> <p>During a review of the facility ' s P&P titled, Oxygen Administration, dated [DATE], indicated to prevent or reverse hypoxia and provide oxygen to the tissues, the facility will, in an emergency situation or when a physician's order cannot be immediately obtained, oxygen may be initiated by a Licensed Nurse in the presence of acute chest pain or any other acute situation in which hypoxia is suspected. A physician is to be contacted as soon as possible after initiation of oxygen therapy in emergency situations, for verification and documentation of the order for oxygen therapy consultation, and further orders. Oxygen saturations will be measured and documented at a minimum of daily for resident's receiving oxygen therapy.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>50012</p> <p>Based on observation, interview, and record review, the facility did not ensure that one of three sampled residents (Resident 46), was free from the use of physical restraints (anything that inhibits the resident freedom of movement (any change in place or position for the body or any part of the body that the person is physically able to control) and staff convenience.</p> <p>Resident 46 was observed from 11AM to 2:35PM on 12/3/2024 to in a Geri Chair (Geriatric chair a specialized chair with large pad and with wheels designed to assist seniors with limited mobility) with lap table attached to the Geri chair that the resident could not easily remove.</p> <p>This deficient practice had the potential to result in entrapment (an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail), injury and a decline in resident's mobility and/or perform activities of daily living.</p> <p>Findings:</p> <p>During a review of Resident 46 ' s Admission Record (Face Sheet), dated 12/4/2024, the face sheet indicated the facility admitted Resident 46 on 12/4/2022, with diagnoses including Alzheimer's disease (progressive mental deterioration), and diabetes mellitus (DM: long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin).</p> <p>During a review of Resident 46 ' s History and Physical (H&P), dated 7/18/2024 indicated, Resident 46 does not have the mental capacity to make medical decisions.</p> <p>During a review of Resident 46's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/23/2024, indicated Resident 46 ' s cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and needed supervision to extensive assistance and one-person assist for bed mobility, transfer, dressing, toilet use, and bathing. The MDS did not indicate the use of restraints.</p> <p>During a review of the current physician's orders for the month of 12/2024, there was no documented evidence that the physician ordered Resident 46 to be seated in a Geri Chair with a lap tray.</p> <p>During an observation on 12/3/2024 from 11:18 AM to 2 PM, in Resident 46 ' s room, Resident 46 was in the room sitting on a Geri chair with a lap table. Resident 46 was awake, when interviewed resident was confused and unable to answer questions appropriately. When asked if resident was able to remove the lap table, Resident 46 was not able to comprehend and was not able to follow direction to remove the latch underneath the tray table to pull the table out.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 12/3/2024 at 12:28 PM with Certified Nurse Assistant 1 (CNA 1) in Resident 46 ' s room, CNA 1 stated she assisted Resident 46 to sit up on the Geri Chair at 11AM and that the resident was unable to get up because she was seated in a Geri chair with a lap table. CNA 1 stated Resident 46 was able to walk with assistance, CNA 1 stated the Geri Chair restricts the resident ' s movement, leaving the resident stuck in the chair and limiting the resident ' s freedom to move and ambulate for hours. CNA 1 stated Resident 46 tries to get up on her own and when we stop her she becomes combative. CNA 1 stated Resident 46 required assistance because of unsteady gait (walking in uncoordinated manner) and was at risk of falling. CNA 1 stated that it was easier to care for Resident 46 if she stays in the Geri chair, as she might fall if she tries to get up on her own when unattended. CNA 1 further stated that Resident 46 was typically seated in the Geri chair starting at 11 AM until 2 PM, with the lap table in place to keep her secured while eating snacks and lunch during the day.</p> <p>During an interview on 12/3/2024 at 2:35 PM with the License Vocational Nurse 2 (LVN 2), the LVN 2 stated that the lap table was attached to the Geri chair and was removable, but Resident 46 was unable to remove the tray by herself. the CNA must remove the table to assist her in standing, repositioning, or toileting needs.</p> <p>During an interview on 12/3/2024 at 2:47 PM with the Director of Nursing (DON), the DON stated he was unaware of the use of the Geri chair with lap table for Resident 46. The DON confirmed there was no physician's order in the clinical record for the use of Geri chair with lap table and there was no consent from responsible party for the use of the Geri chair with lap table. DON stated, Resident 46 will not be able to get out of the Geri chair with lap table if Resident 46 was unable to release it on her own. DON further stated when Resident 46 cannot remove the lap table it restricts movement of the resident, the use of it becomes a restraint. During a thorough review of Resident 46's medical record, DON was unable to provide written documentation that an assessment, physician order, consent, care plan and IDT meetings were completed for the use of the lay tray with the Geri chair.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Restraints, revised 2017, indicated Residents shall be given an environment that is restrain-free, unless a restrain is necessary to treat a medical symptom in which case the least restrictive measures shall be used. It also indicated that the Facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. The Facility will ensure that restraints will not be imposed for purposes of discipline or convenience. The policy also indicated Acceptable forms of restrains are cloth vest, soft ties, soft cloth mitten, seat bels and trays with spring release devices.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>48481</p> <p>Based on interview and record review, the facility failed to ensure one of six sampled residents (Residents 35) preadmission screening and annual resident review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) assessment screening was complete to determine the facility's ability to provide the special need of the residents.</p> <p>This deficient practice placed the resident at risk of not receiving necessary care and services they need.</p> <p>Findings:</p> <p>During a review of Resident 35's medical diagnosis dated 4/19/22, indicated the resident was admitted to the facility with diagnoses that included depression (a mental illness that changes your mood), anxiety (a feeling of fear, dread, and uneasiness), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 35's Minimum Data Set (MDS--a federally mandated resident assessment tool) dated 5/1/22, indicated that the resident expressed feeling tired or little energy, moving or speaking so slowly that other people could have noticed, or the opposite- moving so fidgetily or restless that you have been moving around a lot more than usual, and is receiving antipsychotic (treat psychosis, a collection of symptoms that affect your ability to tell what's real and what isn't), antidepressant (prescription medicines to treat depression), and anti-anxiety (help reduce the symptoms of anxiety, panic attacks, or extreme fear and worry) medications on a routine basis.</p> <p>During a review of electronic health record (EHR) a Department of Health Care Services (DHCS) letter to the resident dated 11/10/23 indicated that Positive Level I Screening Indicates a Level II mental Health Evaluation is required. No record of PASRR II in Resident 35 ' s chart or EHR.</p> <p>During an interview on 12/4/24 at 9:55 AM with Director of Nursing (DON), DON stated I don ' t have the access. California State DHCS is the one scheduling and managing PASARR and sending someone to do the eval, our responsibility is to wait for the result and plan our care.</p> <p>During an interview on 12/4/24 at 10:05 AM with Admission Coordinator, Admission Coordinator stated PASARR Screening is important for screening resident ' s mental health and identify residents ' needs for special mental health service. The Admission Coordinator further stated it is the facility's responsibility to ensure the PASARR assessment is complete and clear. Resident 35 ' s Level II Evaluation should have been done. The Admission Coordinator did not have knowledge as to why the Level II Evaluation Report was for Resident 35 ' s was not completed.</p> <p>During a review of the facility's dated policy and procedure titled Preadmission Screening and Annual Resident Review (PASARR), indicated a positive PASARR Level I screen necessitates an in-depth evaluation of the individual by a Level II Contractor, known as PASARR Level II, which must be conducted prior to admission. The PASARR result are maintained in the resident ' s medical records.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan as indicated in the facility ' s policy and procedure and physician ' s order for two of two sampled residents (Resident 54 and Resident 16) by failing to:</p> <p>Develop a plan of care for Resident 54 who had a history of thrombocythemia (a disease that caused the body to many too many platelets) and received antiplatelet therapy (medications that prevent blood clots from forming in arteries [tubes that connect to the heart, which distributes oxygen rich blood to the body] and heart by making platelets [disc-like cells that help stop bleeding, form clots, and helps wounds to heal] less sticky.</p> <p>Develop a plan of care for Resident 16 who exhibited the behaviors of agitation, screaming/yelling, and attempted to hit staff.</p> <p>These failures had the potential for Resident 54 not to be monitored for increased bruising or bleeding. In addition, Resident 16 ' s behavior will not be monitored to ensure interventions are provided to prevent harm to self and others.</p> <p>Findings:</p> <p>1. During a review of Resident 54 ' s Admission Record, the facility admitted Resident 54 on 3/12/2024 with diagnoses that include orthopedic (care related to muscles and bones) aftercare following surgical amputation (surgical procedure to remove a body part after injury or disease), osteomyelitis (inflammation of bone or bone marrow, usually due to infection), and hemorrhagic thrombocythemia (a condition where a resident has low levels of platelets in the body, which makes it difficult to stop bleeding).</p> <p>During a review of Resident 54 ' s Order Summary Report (instructions that communicated the medical care that the resident received while in the facility), with an ordered on 3/13/2024, Resident 54 received Aspirin (Non-steroidal anti-inflammatory medication with a mechanism to decrease the body ' s platelet ability to create clots) 81 milligrams (mg, unit of measure) 1 tablet by mouth once a day and received Clopidogrel Bisulfate (antiplatelet medication that prevents platelets from sticking together and forming a dangerous blood clot) 75 mg 1 tablet by mouth once a day for stroke prevention.</p> <p>During a review of Resident 54 ' s Order Summary Report (instructions that communicated the medical care that the resident received while in the facility), with an order start date of 8/29/2024, Resident 54 was to be monitored for sign and symptoms of bleeding every shift for anticoagulant therapy use.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Glenoaks Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 409 W. Glenoaks Blvd. Glendale, CA 91202	
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 54 ' s Minimum Data Set (MDS, a resident assessment tool), dated 9/19/2024, the MDS indicated Resident 54 ' s cognition (a person ' s mental process of thinking, learning, remembering, and using judgement) was severely impaired. The MDS indicated Resident 54 needed partial assistance (helper does less than half the effort) for toileting hygiene and upper body dressing and needed substantial assistance (helper does more than half the effort) when bathing self. The MDS indicated Resident 54 required supervision assistance (helper provides verbal cues or contact guard assistance as resident completes the activity) when turning side to side in bed or moving from sitting to lying in bed. The MDS indicated Resident 54 received antiplatelet therapy (blood thinner therapy).</p> <p>During a concurrent interview and record review on 12/5/2024 at 2:08PM with Licensed Vocational Nurse (LVN) 5, Resident 54 ' s Order Summary Report and care plans were reviewed. LVN 5 stated, a resident who received anticoagulant therapy should be monitored for any signs and symptoms of bleeding such as bruising, scrapes, or cuts. LVN 5 stated, there was no care plan created to monitor Resident 54 for increased risk of bleeding related to anticoagulant therapy. LVN 5 stated, it was important to create a care plan to look out for the resident ' s needs, and care plans were person-centered guidelines to help care the resident.</p> <p>During a concurrent interview and record review on 12/5/2024 at 2:18PM with the Director of Nursing (DON), Resident 54 ' s Order Summary Report and care plans were reviewed. The DON stated, Resident 54 did not have a care plan to monitor for signs and symptoms of bleeding. The DON stated, a care plan is created to create a plan of how to care for a resident based on their diagnosis and the goal of the care plan is to create interventions that person-centered focus. The DON stated, the risk of not creating a care plan was the interventions may be different from nurse to nurse, and the goal was for the multi-disciplinary team to be on the same page and aware of what cares and interventions were specific to the resident.</p> <p>50012</p> <p>2. During a review of Resident 16 ' s Admission Record (Face Sheet), dated 12/4/2024, the face sheet indicated the facility admitted Resident 16 on 5/14/2014, and readmitted on [DATE] with diagnoses including epilepsy (a brain disorder that can cause people to suddenly become unconscious and have violent, uncontrolled movements of the body), and intellectual disabilities.</p> <p>During a review of Resident 16 ' s History and Physical (H&P), dated 6/27/2024 indicated, Resident 16 does not have the mental capacity to make medical decisions.</p> <p>During a review of Resident 16's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/29/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and needed supervision to extensive assistance from the staff for the activities of daily living.</p> <p>During a review of Resident 16's care plan on 12/4/2024, indicated there was no care plan developed to address the resident ' s behavior of agitation, screaming/yelling, attempting to hitting staff members.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 16's Order Summary Report, dated 12/4/2024, the Order Summary Report indicated an order on 10/15/2024/ psychiatric consult due to agitation, screaming/yelling, and attempting to hit staff.</p> <p>During an interview on 12/3/2024 at 3:38 PM with the Director of Nursing (DON), the DON stated that care plans are essential communication tools for the care team, ensuring everyone knows the strategies for managing challenging behaviors. Without a proper care plan, opportunities to identify triggers, implement preventive actions, and track outcomes are missed.</p> <p>During an interview on 12/5/2024 at 1:45 PM with, the Licensed Vocational Nurse 2 (LVN 2) stated the importance of care plans in providing individualized, consistent, and effective care. LVN 2 stated that a care plan should have been developed to manage the resident ' s behaviors, such as agitation, yelling, and attempts to hit staff. LVN 2 stated that without a care plan, staff may struggle to respond effectively, leading to inconsistent or inadequate interventions and increasing the risk of harm to both the resident and staff.</p> <p>During a review of the facility ' s policies and procedures (P&P), Care Planning, revised on 10/24/2022, the P&P indicated the care plans served as a course of action to help the resident move toward resident-specific goals that address the resident ' s medical, nursing, mental, and psychosocial needs. The P&P indicated, the care plan will include measurable objectives and timetables to meet a resident ' s medical, nursing, mental, and psychosocial needs, and the care plan will include services needed to maintain the resident ' s highest practicable physical, mental, and psychosocial well-being.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 54) was provided care and services for the infected nails by consulting the Dermatology (medicine specialized in treating skin, hair and nails) and Podiatry (medicine specialized in treating foot, ankle, and related structures of the leg) every 2 months and as needed for mycotic (fungal infection that affected the fingernails or toenails) and hypertrophic (nails that are abnormally thickened or misshapen) of the fingernails as ordered by the physician and in accordance with the plan of care.</p> <p>Resident's 54 ' s bilateral fingernails were observed thickened, dry, brittle, and broken after being caught in a blanket.</p> <p>This failure resulted in the resident's nails to fall off and progressive severe infection and pain or discomfort that could lead to hospitalization .</p> <p>Findings:</p> <p>During a review of Resident 54 ' s Admission Record, the facility admitted Resident 54 on 3/12/2024 with diagnoses that included orthopedic (care related to muscles and bones) aftercare following surgical amputation, Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage that can occur in people with DM), bilateral glaucoma (fluid buildup in the eye which causes vision loss and blindness), hemorrhagic thrombocytopenia (a blood disorder where the body creates too many platelets shape), acquired absence of right leg above knee, and acquired absence of left leg above knee.</p> <p>During a review of Resident 54 ' s Skin Observation Checks, dated 3/13/2024, there was no documented evidence that Resident 54 was provided nail care and treatments.</p> <p>During a review of Resident 54 ' s Minimum Data Set (MDS, a resident assessment tool), dated 3/19/2024, Resident 54 had severely impaired cognition (a person ' s mental process related to thinking, learning, remembering, and using judgement). The MDS indicated Resident 54 had moderately impaired (limited vision; not able to see newspaper headlines but can identify objects) vision. The MDS indicated Resident 54 required moderate assistance (helper does less than half the effort) for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) and moderate assistance for functional mobility (a person ' s ability to move safely and independently within their environment).</p> <p>During a review of Resident 54 ' s MDS, dated [DATE], indicated Resident 54 had severely impaired cognition that required moderate assistance (helper does less than half the effort) for ADLs and functional mobility. T</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 54 ' s Order Summary Report (a physician's order) dated 3/12/2024, indicated an ordered for Dermatology (medicine specialized in treating skin, hair and nails) consult and management/treatment for Podiatry (medicine specialized in treating foot, ankle, and related structures of the leg) consult every 2 months and as needed for mycotic (fungal infection that affected the fingernails or toenails) and hypertrophic (nails that are abnormally thicken or misshapen) nails.</p> <p>During a review of Resident 54 ' s care plans, revised on 9/18/2024, indicated a podiatry consult with a goal for Resident 54 to receive adequate care treatment daily. The care plan interventions included provide evaluation for referral podiatry consult as needed.</p> <p>During an observation on 12/3/2024 at 11:35AM in Resident 54 ' s room, Resident 54 ' s bilateral hands and fingernails were observed with a dark red and scabbed nail bed, swollen and with redness around the cuticle (the area at the base of the nail). Resident 54 ' s right hand, the thumb, index, middle, and pinky fingers were brittle, dry, and overgrown. On Resident 54 ' s left hand, the thumb, middle, ring, and pinky fingers appeared brittle, dry, and overgrown.</p> <p>During a phone interview on 12/3/2024 at 2:15PM with Family Member (FM) 1, FM 1 stated, Resident 54 ' s bilateral hands fingernails appear to have fungus to me. FM 1 stated, Resident 54 ' s fingernails looked like this for a long time even before being admitted to the facility.</p> <p>During an interview on 12/3/2024 at 3:47PM in Resident 54 ' s room, Resident 54 stated, last night, his right hand was caught on the blanket, and the nail on his right ring fingernail fell off. and now it hurts.</p> <p>During a concurrent observation on 12/5/2024 at 8:24AM in Resident 54 ' s room, Resident 54 ' s bilateral hands were observed with the right ring fingernail bed appeared dark reddish in color and scabbed and with the right pinky fingernail appeared to have partially fallen off with a dark reddish color noted on half of the fingernail. In an interview Resident 54 stated, the right pinky fingernail fell off yesterday in the shower. The pain is 4/10. Resident 54 stated, his fingernails always grow in height and then falls off.</p> <p>During an interview on 12/5/2024 at 9:20AM with Certified Nurse Assistant (CNA) 7, CNA 7 stated, the podiatrist cuts the nails of higher risk residents such as diabetic residents or residents with long nails. CNA 7 stated, she would notify the charge nurse or the treatment nurse if a resident ' s nails appear abnormal. CNA 7 stated, there were no issues with Resident 54 ' s nails.</p> <p>During an interview on 12/5/2024 at 9:28AM with CNA 6, CNA 6 stated, she observes a resident ' s fingernails when in the shower. CNA 6 stated, if there was something wrong with a resident ' s fingernails, I will inform the Charge Nurse right away. CNA 6 stated, last week, Resident 54 ' s fingernails were a little long but they looked normal.</p> <p>During a concurrent observation and interview on 12/5/2024 at 9:45AM with CNA 6, Resident 54 ' s bilateral hands and fingernails were observed. CNA 6 stated, Resident 54 ' s fingernails did not appear normal. CNA 6 stated, Resident 54 ' s fingernails looked sick. I would inform the Charge Nurse right as soon as possible because the nurse needs to be informed.</p> <p>During an interview on 12/5/2024 at 10:20AM with Licensed Vocational Nurse (LVN) 5, LVN 5 stated, Resident 54 had overgrowth on almost on all nails on his bilateral hands for months.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 12/5/2024 at 10:40AM with LVN 5 and Resident 54 in Resident 54 ' s room, Resident 54 ' s bilateral right ring and pinky fingernails had dark dried blood and the right middle, index, and thumb fingernails were overgrown. LVN 5 stated, Resident 54 ' s left thumb and ring fingernails were overgrown, Resident 54 ' s left pinky fingernail were long and thickened. LVN 5 stated, Resident 54 ' s she saw the overgrowth nails of Resident 54 yesterday, but did not notice the redness of the ring and pinky fingernails of the right hand. LVN 5 stated, Resident 54 ' s bilateral fingernails could be a fungal issue that could spread to the rest of his skin and nails. LVN 5 stated, if it was not taken care of, it could lead to an infection and to hospitalization .</p> <p>During an interview on 12/5/2024 at 10:40AM with LVN 5 and Resident 54, Resident 54 stated, he had 4 out of 10 pain level around the nail cuticle of his right ring and pinky finger. Resident 54 stated, his bilateral thumb nails have fallen off before.</p> <p>During a concurrent interview and record review on 12/5/2024 at 11:10AM with LVN 5, Resident 54 ' s Admission Record, Order Summary Report, CoC, Care Plans, Interdisciplinary Team (IDT, a meeting where different healthcare professionals discuss a resident ' s needs and plan of care) meeting, and progress notes (a record documented by the healthcare professionals to document a patient ' s current condition and treatment response) were reviewed. LVN 5 stated, the physician was not notified of Resident 54 ' s nails because there was no CoC, no current oral or topical treatment, no IDT meeting, and no podiatry consultation notes in Resident 54 ' s medical records (written or electronic record of a resident ' s health history). LVN 5 stated, there was no nursing progress notes, no assessment, and no care plans about Resident 54 ' s nails in his medical records. LVN 5 stated, if Resident 54 ' s ring and pinky fingernails did not stop bleeding, Resident 54 could have experienced unstoppable bleeding.</p> <p>During an interview on 12/5/2024 at 11:37AM with Registered Nurse (RN) 1, RN 1 stated, she was not aware of any issues regarding Resident 54 ' s bilateral fingernails.</p> <p>During a concurrent observation and interview on 12/5/2024 at 11:45AM in Resident 54 ' s room with Resident 54, RN 1, and LVN 5, Resident 54 ' s bilateral fingernails were observed. RN 1 stated, Resident 54 ' s nails were not normal, and a physician needed to be notified about the residents' fingernails. RN 1 stated, Resident 54 ' s fingernails have fungus and were rough looking fingernails. RN 1 stated, she was not aware that Resident 54 had this issue.</p> <p>During a concurrent interview and record review on 12/5/2024 at 1:00PM with RN 1, Resident 54 ' s Admission Record, Order Summary Report, and lab results were reviewed. RN 1 stated, if his nails were not treated, the fungus could become an infection, and the infection could lead to Resident 54 being hospitalized and losing his bilateral upper extremities.</p> <p>During a review of the facility ' s policies and procedures (P&P), Grooming Care of the Fingernails and Toenails, revised 6/1/2017, the P&P indicated high risk residents ands residents with hypertrophic, mycotic, and keratotic (thicken of nails) toenails will be referred to podiatrist.</p> <p>During a review of the facility ' s P&P, Policy and Procedure for Podiatry Consult, no date, the P&P indicated, it was the P&P of the facility to provide the service for podiatry consult due to the following: 1. As needed, 2. Resident consult must be put in the cart.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s P&P, Care and Services, revised 6/1/2017, the P&P indicated, residents were provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being level in an environment that enhances quality of life. The P&P indicated, the resident received an admission assessment where initial care and service needs were identified.</p> <p>During a review of the facility ' s P&P, Change of Condition Notification, revised 6/1/2017, the P&P indicated, the facility will inform the resident, attending physician, and notify the resident ' s legal representative when the resident endured a significant change in the resident ' s physical, cognitive, behavioral, or functional status. The P&P indicated, the physician will be notified timely with a resident ' s change in condition.</p> <p>During a review of the facility ' s P&P, Care Planning, revised 10/24/2022, the P&P indicated, that each comprehensive care plan will describe the services that were to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012</p> <p>Based on observation, interview, and record review, the facility failed to ensure the residents who were admitted to the facility with intact skin did not develop a pressure injury to skin and underlying tissue resulting from prolonged pressure on the skin or bony prominences) for one of three sampled residents (Resident 22) who had Stage 3 pressure injury (is a wound where the skin is completely broken, and the damage extends into the deeper layers of tissue beneath it) was not kept clean to prevent recurrent pressure injury.</p> <p>This failure resulted in delayed healing and reopening of the healed pressure injury on the sacrum (a triangular-shaped bone located at the base of the spine, forming the posterior wall of the pelvis).</p> <p>Findings:</p> <p>During a review of Resident 22 ' s Admission Record (Face Sheet), the facility admitted Resident 22 on 5/1/2019 and readmitted on [DATE] with diagnoses that included Alzheimer's disease (progressive mental deterioration), and epilepsy (a brain disorder that can cause people to suddenly become unconscious and have violent, uncontrolled movements of the body).</p> <p>During a review of Resident 22's Admission Assessment, dated 5/1/2019, the Admission Assessment indicated the resident had intact skin.</p> <p>During a concurrent interview and record review on 12/6/2024 at 9:15 AM with Treatment nurse (TN) Resident 22 ' s the following documents were reviewed:</p> <p>COC (change of condition) Interact Assessment Form -a communication Checks, indicated on 7/26/2024 at 12:52 PM, Resident 22 developed a Deep tissue pressure injury (DTI) is a type of severe damage to the deeper layers of skin and tissue beneath it, often caused by pressure or a lack of blood flow.) on Sacrum (tailbone) area and the physician recommended to refer the resident to a wound consultant. COC Interact Assessment Form indicated on 8/2/2024 at 3:22 PM, Resident 22 ' s sacral DTI advanced to Stage 3 pressure injury.</p> <p>Skin Observation Checks, dated 8/2/2024, indicated Resident 22 had a Stage 3 in the sacrum area, measuring 3.0 centimeters (cm) in length, 3.6 cm in width, 0.3cm depth, 100 percent (%) granulation (new tissue) tissue with no sign and symptoms (s/s) of any infection, no foul odor,</p> <p>Skin Observation ?Checks,? dated 8/9/2024 was reviewed. The document indicated Resident 22 had a Stage 3 in the sacrum area, measuring 3.0 cm in length, 2.5 cm in width, 0.3 cm depth, wound remains stable and adequately healing, area noted with 100 % granulation tissue with no s/s of any infection, no foul odor, peri-wound (around the wound) remain intact resident denies pain/discomfort</p> <p>Skin Weekly Assessment, dated 8/16/2024 the document indicated Resident 22 had acquired a Stage 3 in the sacrum area, on 8/2/2024. Document also indicated ulcer healed and discontinued previous order due to due to wound is now healed. New orders Cleanse with normal saline ([NS]- sterile salt solution), pat dry, apply Zinc oxide (is a medicated cream, ointment or paste) for skin management.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Admission Assessment, dated 8/26/2024, indicated Resident 22 had intact skin.</p> <p>Skin Observation Checks, dated 8/27/2024 the document indicated Resident 22 skin was intact.</p> <p>COC Interact Assessment Form -a communication Checks, indicated on 9/4/2024 at 1:18 PM, Resident 22 ' s sacral pressure injury re-opened to Stage 3 pressure injury, the physician recommendations of Primary Clinician: wound consult and LAL (low-air loss- mattress designed to prevent and treat pressure injuries by reducing moisture and heat buildup) mattress.</p> <p>Braden Scale for Predicting Pressure Ulcer Risk (Checks commonly used in health care to assess and document a resident ' s risk for developing pressure ulcers), dated 8/27/2024 timed at 12:24 PM, indicated Resident 22 was bedbound and had very limited mobility making position changes to the body or extremities (arms/legs) independently as factors for pressure ulcer development. The Braden Scale indicated Resident 22 had a score of 10, indicating the resident was at high risk for developing pressure ulcers.</p> <p>During a review of Resident 22's Minimum Data Set (MDS-a federally mandated resident assessment Checks), dated 09/4/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired. The MDS indicated Resident 22 was dependent on staff for activities of daily living (ADL) including toileting, hygiene, and showering.</p> <p>During a review of Resident 22 ' s History and Physical (H&P), dated 10/20/2024 indicated, Resident 22 does not have the mental capacity to make medical decisions.</p> <p>During a review of Resident 22 ' s care plan for Resident is at risk for further skin breakdown dated 6/15/2024, the care plan indicated a goal Resident will have no further development of pressure ulcer daily. One of the care plan interventions was to reposition the resident every two hours.</p> <p>During an interview and record review on 12/6/2024 at 9:15 AM with Treatment Nurse 1 (TN 1), TN 1 stated that Resident 22 developed a stage 3 pressure ulcer (PU) on the sacrum on 7/26/2024, which healed by 8/16/2024 but reopened on 9/4/2024. TN1 stated the resident was identified as high risk for pressure injury upon admission, with intact skin. TN 1 stated Resident 22 was fully dependent on staff for repositioning, toileting. TN 1 stated there are days when she finds the residents with pressure injury with soiled incontinent briefs that had not been changed during the night which could cause a delay in healing of the pressure ulcer. TN 1 stated there was no medical reason preventing proper repositioning.</p> <p>During an interview and record review on 12/6/2024 at 9:15 AM with TN1, TN 1 stated 1, the wound was avoidable with proper repositioning and incontinence care. TN 1 stated Resident 22 cannot communicate when wet or soiled and relies entirely on staff for assistance. TN 1 stated that with proper staff intervention the reopening of the wound could have prevented.</p> <p>During a record review of the facility ' s Policy and Procedure (P&P) titled, Pressure ulcer prevention, revised date 6/2017, the P&P indicated the facility The facility will identify residents at risk for pressure ulcers and provide care and services to promote the prevention of pressure ulcer development.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203</p> <p>Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services to care for two of three sampled residents (Resident 65 and Resident 36) with indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine and left in place for a set amount of time). Resident 65 and 36 with indwelling catheter was observed with presence of sediments (particles free floating in urine that could be sign of infection) in the urine that was not assessed, documented and reported to the physician.</p> <p>These failures had the potential to result in a delay in treatments, interventions, and services to treat a possible UTI (an infection in the urinary tract- urethra, bladder, utterer and kidney), which could lead to a resident ' s increased confusion, sepsis (a life-threatening blood infection), hospitalization , and possibly death.</p> <p>Findings:</p> <p>1. During a review of Resident 65 ' s Admission Record, the facility admitted Resident 65 on 2/2/2024 and readmitted Resident 65 on 6/7/2024 with diagnoses that included metabolic encephalopathy (a brain disorder that occurred when a chemical imbalance in the blood affects the brain) and acute kidney failure (kidneys suddenly stop working).</p> <p>During a review of Resident 65 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the resident ' s health status), dated 6/17/2024, Resident 65 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 65 ' s Minimum Data Set (MDS, a resident assessment tool) dated 11/11/2024, the MDS indicated Resident 65 has severely impaired cognition (a person ' s mental process of thinking, learning, remembering, and using judgement). The MDS indicated Resident 65 was dependent (helper does all the effort. Resident does none of the effort to complete an activity) for all activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) and functional mobility (a person ' s ability to move safely and independently within their environment). The MDS indicated Resident 65 had an indwelling catheter.</p> <p>During a review of Resident 65 ' s Order Summary Report (a physician ' s order) dated 2/3/2024, indicated Resident 65 ' s indwelling catheter needed to be monitored and documented for sediments, foul odor, hematuria (blood in urine), or bladder distention (the bladder was stretched beyond its normal capacity due to blockage in the urinary tract). The physician order indicated to document (Y) if noted and to notify the physician, and to document (N) if none noted.</p> <p>During a review of Resident 65 ' s Order Summary Report, dated 2/3/2024, Resident 65 ' s indwelling catheter may be flushed with 60 milliliters (mL, unit of measure) of normal saline solution (NS) as needed for increased sediments.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 65 ' s care plan, revised on 11/13/2024, Resident 65 had an indwelling catheter with interventions that included monitoring for signs and symptoms for UTI such as pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased heart rate, increased temperature, foul smelling urine, and a change in behavior.</p> <p>During a review of Resident 65 ' s Treatment Administration Record (TAR, a record of a resident ' s treatment in the resident ' s medical record), for the month December 2024, was reviewed. The TAR indicated Resident 65 ' s indwelling catheter was assessment for 12/3/2024 but did not indicate whether the indwelling catheter had sediments, foul odor, hematuria, or bladder distention.</p> <p>During a review of Resident 65 ' s TAR, for the month of December 2024, indicated Resident 65 ' s indwelling catheter was not flushed with 60 mL of NS on 12/3/2024.</p> <p>2. During a review of Resident 36 ' s Admission Records, the facility admitted Resident 36 on 2/3/2024 and readmitted Resident 36 on 8/1/2024 with diagnoses that included encephalopathy (a change in a resident ' s brain function), generalized osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and an overactive bladder (increased urge to urinate that may be hard to control).</p> <p>During a review of Resident 36 ' s H&P, dated 9/10/2024, the H&P indicated Resident 36 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 36 ' s MDS, dated [DATE], the MDS indicated that Resident 36 ' s cognition was severely impaired. The MDS indicated Resident 36 required dependent assistance for all ADLs and functional mobility. The MDS indicated Resident 36 had an indwelling catheter.</p> <p>During a review of Resident 36 ' s Order Summary Report, dated /2/2024, indicated Resident 36 ' s indwelling catheter needed to be monitored and documented for sediments, foul odor, hematuria, or bladder distention. The order indicated to document (Y) if noted and to notify the physician, and to document (N) if none noted.</p> <p>During a review of Resident 36 ' s Order Summary Report, with an order start date of 8/2/2024, Resident 36 ' s indwelling catheter may be flushed with 60 mL of NS as needed for increased sediments.</p> <p>During a review of Resident 36 ' s care plan, revised on 11/12/2024, Resident 36 had an indwelling catheter and was at risk for development of complications such as developing a UTI with interventions that included monitoring for signs and symptoms of UTIs such as pain, burning, blood-tinged urine, cloudiness, deepening of urine color, increase heart rate, increase temperature, foul smelling urine, and a change in behavior.</p> <p>During a review of Resident 36 ' s TAR, for the month of December 2024, was reviewed. The TAR indicated Resident 36 did not have sediments in the indwelling catheter for 12/3/2024.</p> <p>During a review of Resident 36 ' s TAR, for the month of December 2024, was reviewed. The TAR indicated Resident 36 ' s indwelling catheter was not flushed with 60mL of NS for 12/3/2024.</p> <p>During an observation on 12/3/2024 at 9:05AM in Resident 36 ' s room, Resident 36 ' s indwelling catheter had sediments in the tubing.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 12/3/2024 at 9:30AM in Resident 65 ' s room, Resident 65 ' s indwelling catheter had sediments in the tubing.</p> <p>During a concurrent observation and interview on 12/4/2024 at 4:21PM with Licensed Vocational Nurse (LVN) 9, in Resident 36 ' s room, Resident 36 ' s indwelling catheter had sediment urine draining into the tubing. LVN 9 stated, there was a bit of sediment present in the indwelling catheter tubing.</p> <p>During a concurrent observation and interview on 12/4/2024 at 4:25PM with LVN 9, in Resident 65 ' s room, Resident 65 ' s indwelling catheter had sediment in the tubing. LVN 9 stated, there was some sediment present in the indwelling catheter tubing.</p> <p>During an interview on 12/4/2024 at 4:30PM with LVN 9, LVN 9 stated, he was unaware of the sediment in Resident 36 ' s and Resident 65 ' s urine. LVN 9 stated, Resident 36 and 65 ' s urine should be clear, and there should not be any cloudiness or sediment in the urine. LVN 9 stated, part of indwelling catheter care included following the physician ' s order for flushing the indwelling catheter for irrigation (a procedure that used NS to clear a blocked catheter and remove debris from the bladder) and monitoring the urine for cloudiness, sediments, urine color, or foul odor.</p> <p>During a concurrent interview and record review on 12/4/2024 at 4:45PM with LVN 9, Resident 36 and Resident 65 ' s Change of Condition Evaluation (CoC, a document used to record a resident ' s change of condition, required notifications to physicians and responsible parties, care plan updates, and physician orders), Nursing Progress Notes (a written record that a nurse keeps about a resident ' s health status), and TAR were reviewed. LVN 9 stated, the physician was not notified of Resident 36 and Resident 65 ' s sediment in the indwelling catheter because there was no CoC or nursing progress notes documented. LVN 9 stated, there was a place to document sediment in the urine in the TAR, and it was not documented. LVN 9 stated, the LVNs would document the sediment in the indwelling catheter in the TAR, document a progress note, create a CoC to notify the physician, and create a care plan. LVN 9 stated, sediment in the urine could lead to a UTI, and if the UTI was not properly treated, the resident could become hospitalized .</p> <p>During an interview on 12/6/2024 at 7:30PM with the Director of Nursing (DON), the DON stated, if there was hematuria, sediment, or foul odor noted in a resident ' s indwelling catheter, the physician should be notified. The DON stated, there was a place in the TAR for the licensed nurses to document any abnormal assessments of the indwelling catheter. The DON stated, it was important to assess the urine in the indwelling catheter because if there was sediment in the tubing, it could lead to blockage of the indwelling catheter tubing. The DON stated, this blockage could lead the urine to be backed up in the urinary tract and this could become a UTI.</p> <p>During a review of the facility ' s policies and procedures (P&P), Catheter - Care of, revised on 6/1/2017, the P&P indicated, a resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible. The P&P indicated, to report signs and symptoms of UTI to the attending physician such as fever, changes in urine such as foul odor or bloody/cloudy appearance.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility ' s P&P, Change of Condition Notification, revised on 6/1/2017, the P&P indicated the facility will notify the resident ' s attending physician when the resident has a significant change in the resident ' s physical, cognitive, behavioral, or functional status. The P&P indicated a Licensed Nurse will document the date, time, and details of the incident and the assessment in the nursing notes, the time the physician was notified, and their recommendations.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203</p> <p>Based on interview and record review the facility failed to ensure residents who have a Gastrostomy Tube (GT, a tube surgically inserted into the stomach or small intestines used to deliver fluids and medications) receive treatment and services to prevent complications such as peritonitis (redness and swelling (inflammation) of the lining of the abdomen, and perforation (a small hole) in the peritoneal (lining of the abdominal cavity) and spillage of gastric (acidic fluid in the stomach) contents in the abdominal tissue) for one of three sampled residents (Resident 1) who had GT placed since 2/2024, that the resident pulls out due to confusion.</p> <p>This failure resulted in Resident 1 having seven repeated hospitalizations to the general acute care hospital (GACH) for G-tube dislodgement, had the potential to result in trauma and infection to the g-tube stoma (a small opening in the abdomen), and had the potential to result in Resident 1 experiencing dehydration and malnutrition.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the facility admitted Resident 1 on 11/17/2023 and readmitted Resident 54 on 9/7/2024 with diagnoses that included muscle wasting (loss of muscle mass and strength), dementia (a progressive state of decline in mental abilities), major depressive disorder (a serious mental health condition that causes persistent low mood) with severe psychotic (a person loses the ability to recognize reality) symptoms, and g-tube malfunction.</p> <p>During a review of Resident 1's Skin Check Observation document, dated 2/18/2024, the document indicated, Resident 1 previous G-tube site was in the upper middle area of the abdomen. The document indicated, Resident 1's active G-tube site was in the lower middle area of the abdomen.</p> <p>During a review of Resident 1's Skin Check Observation document, dated 4/6/2024, the document indicated Resident 1 had a G-tube site in her abdomen.</p> <p>During a review of Resident 1's Skin Check Observation document, dated 7/13/2024, there was no documented evidence of Resident 1's G-tube site location.</p> <p>During a review of Resident 1's care plan, revised on 7/15/2024, Resident 1 required enteral nutrition feeding (deliver nutrients and fluids directly to the stomach) and Resident 1's G-tube dependent with interventions that included monitoring the insertion site for infection or skin breakdown.</p> <p>During a review of Resident 1's care plan, revised on 7/15/2024, Resident 1 had a behavior problem related to anxiety disorder manifested by pulling out the g-tube, agitation, and restlessness. The care plans review included Resident 1 receiving Buspirone HCL (anti-anxiety medication), 10 milligrams (mg, unit of measure), 1 tablet by G-tube two times a day for anxiety manifested by restlessness as evidenced by pulling her G-tube.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Skin Check Observation dated 8/3/2024, the document indicated Resident 1 ' s skin was intact, and the G-tube was patent and intact. The document did not indicate the location of the G-tube site.</p> <p>During a review of Resident 1 ' s Skin Check Observation document, dated 8/4/2024, the document indicated Resident 1 ' s Skin was intact, and the G-tube was patent and intact. The document did not indicate the location of the G-tube site.</p> <p>During a review of Resident 1 ' s care plan, revised on 8/4/2024, Resident 1 had bilateral hand mitten restraints (soft protective padding protection wore on both hands) and abdominal binder (compression belt that is worn around the abdomen) with interventions that included alternatives to restraining the resident were frequent visual checks and resident needed close monitoring when restraint was removed to prevent G-tube dislodgement.</p> <p>During a review of Resident 1 ' s Siderail/Restraints/Device Assessment, dated 8/4/2024, Resident 1 had bilateral mittens applied because of multiple hospital transfers related to G-tube dislodgement despite the use of an abdominal binder.</p> <p>During a review of Resident 1 ' s care plan revised on 8/20/2024, Resident 1 pulled out her G-tube with interventions that included attempt to determine the pattern or cause for behavior.</p> <p>During a review of Resident 1 ' s Skin Check Observation document, dated 9/8/2024, there was no document evidence of Resident 1 ' s G-tube site location.</p> <p>During a review of Resident 1 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of a resident ' s health status), dated 9/10/2024, Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s care plan, revised on 9/10/2024, Resident 1 required tube feeding for enteral feeding every shift with interventions that included using the abdominal binder to maintain placement of the G-tube.</p> <p>During a review of Resident 1 ' s care plan, revised on 9/26/2024, Resident 1 had a G-tube replacement due to the resident pulling out her G-tube with interventions that included identifying what may have caused Resident 1 to remove the G-tube when possible.</p> <p>During a review of Resident 1 ' s Order Summary Report (instructions that communicated the medical care that the resident received while in the facility), with an order start date of 10/9/2024, the Order Summary Report indicated Resident 1 received Buspirone HCL 10 mg, 1 tablet by G-tube twice a day for anxiety manifested by frequently attempting to pull out the G-tube feeding.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment tool) dated 10/17/2024, Resident 1 ' s cognitive (a person ' s mental process of thinking, learning, remembering, and using judgement) skills for daily decisions making were severely impaired. The MDS indicated Resident 1 was dependent (helper does all the effort for the resident to complete the activity) for all activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) and required maximal assistance (helper does more than half the effort) for functional mobility (a person ' s ability to move safely and independently within their environment). The basic categories include nasogastric [a thin tube inserted through the nose into the stomach] or G-tube) to receive her proper nourishment, fluids, and medications.</p> <p>During a review of Resident 1 ' s care plan, revised on 10/18/2024, Resident 1 continued to have enteral nutritional feeding with interventions to keep Resident 1 ' s head of up always elevated at least 30 degrees and to monitor the insertion site for infection or breakdown.</p> <p>During a review of Resident 1 ' s Order Summary Report, with an order start date of 10/30/2024, the Order Summary Report indicated Resident 1 received Seroquel (anti-psychotic medication) 25 mg, 1 tablet by G-tube once a day for psychosis manifested by constantly pulling out her G-tube.</p> <p>During a concurrent interview and record review on 12/6/2024 at 2:30PM with the Minimum Date Set Nurse (MDSN), Resident 1 ' s Change of Condition (CoC, a document used to record a resident ' s change of condition, required notification to the physician and responsible parties, care plan updates, and physician orders) and nursing progress notes (a written record that a nurse keeps about a resident ' s health status) were reviewed. The MDSN stated, Resident 1 had a history of pulling out her G-tube and was transferred out to the general acute hospital multiple times in 2024. The MDSN stated, Resident 1 ' s g-tube dislodgement timeline was:</p> <p>5/7/2024 - Resident 1 pulled out her G-tube and was replaced at bedside by the Wound Care Company (WCC).</p> <p>6/8/2024 - Resident 1 pulled out her G-tube and was transferred to GACH 1 and readmitted to the facility on [DATE].</p> <p>7/9/2024 - Resident 1 pulled out her G-tube and was transferred to GACH (unable to identify) and readmitted to the facility on [DATE].</p> <p>7/15/2024 - Resident 1 pulled out her G-tube, was transferred to GACH 1 on 7/16/2024, and was readmitted to the facility on [DATE].</p> <p>8/2/2024 - Resident 1 pulled out her G-tube, was transferred to GACH 1 on 8/2/2024, and readmitted back to the facility on [DATE].</p> <p>8/30/2024 - Resident 1 pulled out her G-tube, was transferred to GACH 1 on 8/30/2024, and readmitted back to the facility on [DATE].</p> <p>9/12/2024 - Resident 1 pulled out her G-tube, an order was placed to re-insert G-tube, and obtain an abdominal x-ray (imaging to take a picture of a resident ' s stomach) to ensure placement. The x-ray results indicated the G-tube was in place.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/4/2024 - Resident 1 pulled out her G-tube, was transferred to GACH 1 on 12/4/2024, and readmitted back to the facility on [DATE].</p> <p>During an interview on 12/5/2024 at 2:30PM with the MDSN, the MDSN stated, Resident 1 ' s care plans should have been revised and updated with other interventions tried. The MDSN stated, there was not an Interdisciplinary Team (IDT, a group of healthcare professionals to create a comprehensive care plan for a resident) meeting done after each incident to determine the reason why Resident 1 keeps pulling out her G-tube and what other interventions should have been implemented.</p> <p>During an interview on 12/5/2024 at 3:36PM with Licensed Vocational Nurse 8, LVN 8 stated, Resident 1 has been transferred to GACH recently for pulling out her G-tube. LVN 8 stated, some interventions to prevent g-tube dislodgement included the abdominal binder, reposition resident every two hours to monitor if resident has pulled out her G-tube, keep the head of bed elevated, and to check if the abdominal binder was on the Resident. LVN 8 stated, he was not sure if Resident 1 had the abdominal binder on before her transfer to GACH 1 on 12/4/2024.</p> <p>During an interview on 12/5/2024 at 3:51PM with Registered Nurse (RN) 1, RN 1 stated Resident 1 had a history of pulling out her G-tube. RN 1 stated, the facility attempted to place resident with mitten restraints, but Resident 1 was able to remove the mittens. RN 1 stated, Resident 1 had an abdominal binder but Resident 1 was able to put her hand under the abdominal binder and pull out her G-tube. RN 1 stated, Resident 1 ' s room was close to the nursing station for closer supervision. RN 1 stated, she reminded the Certified Nurse Assistants (CNAs) to do their charting outside of Resident 1 ' s room and to closely supervise Resident 1. RN 1 stated, she cannot recall if there was a CNA outside of Resident 1 ' s room for each incident and was unable to recall if Resident 1 had her abdominal binder on.</p> <p>During an interview on 12/6/2024 at 7:30PM with the Director of Nursing (DON), the DON stated, Resident 1 needed more frequent supervise to monitor Resident 1 and her G-tube. The DON stated, the risk of Resident 1 continuing to pull out her G-tube included trauma and infection to the site, dehydration, and malnutrition.</p> <p>During a review of the facility ' s policies and procedures (P&P), Feeding Tube - Site Care, revised 6/1/2017, the P&P indicated the site of a well-established enteral feeding tube will be inspected daily for signs and symptoms of irritation, gastric leakage, or infection.</p> <p>During a review of the facility ' s P&P, Care and Services, revised 6/1/2017, the P&P indicated resident are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being level to enhance the quality of life. The P&P indicated, the facility will have sufficient staff to provide services with appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being as determined by individualized resident assessments and plans of care.</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467</p> <p>Based on observation, interview, and record review, the facility failed to provide the necessary respiratory care and implement interventions in accordance with the resident's needs, care plan, facility policy and professional standards of practice and the physician's order for one of three sampled residents (Resident 77) who had a diagnoses of chronic obstructive pulmonary disease exacerbation (COPD, sudden severe symptoms of a lung disease characterized by poor airflow to the lungs that results in shortness of breath (SOB), difficulty breathing and respiratory distress (a condition that occurs when the body needs more oxygen, resulting in difficulty breathing, rapid breathing, and low blood oxygen levels) and a history of pneumonia (a severe respiratory infection that results in shortness of breath and difficulty breathing) by failing to:</p> <ol style="list-style-type: none"> 1. Monitor and evaluate if the oxygen provided was effective to relieve the resident's respiratory distress and oxygenation in accordance with the resident's care plan for COPD and physician's orders, when Resident 77 experienced shortness of breath (SOB), labored breathing (taking more effort to breath than usual), and an oxygen saturation (blood oxygen level) decreased to 72% (normal range ,d+[DATE]%) while receiving oxygen via nasal cannula (NC- a plastic flexible tubing used to deliver oxygen into the nose) at 2 liters per minute (L/min) on [DATE] at 11:05 PM. 2. Follow physician orders to titrate (adjust) Resident 77's oxygen therapy at ,d+[DATE] L/min to maintain oxygen blood levels of 92% when Resident 77's oxygen saturation decreased to 72% on [DATE] at 12:10 AM, while receiving 2 L/min of oxygen via NC. 3. Ensure Licensed Vocational Nurse (LVN) 6 monitored and documented Resident 77's respiratory distress, treatments rendered (given), and report Resident 77's change in respiratory condition to the physician, in accordance with the physician orders and the facility's policy and procedure. 4. Ensure to notify the physician and 911 (an emergency number) emergency services immediately, when Resident 77 complained of not being able to breathe and exhibited signs and symptoms of respiratory distress as manifested by labored breathing and oxygen saturation of 72% on [DATE] at 12:10 AM. 5. Ensure the physician was aware that Resident 77 was refusing to go to the hospital while complaining of not being able to breath and exhibited signs and symptoms of respiratory distress as manifested by labored breathing and oxygen saturation of 72% on [DATE] at 12:10 AM. <p>As a result of these deficient practices Resident 77 did not receive immediate respiratory care and interventions on [DATE] from 11:05 PM when the resident was initially observed with respiratory distress, labored breathing, decreased level of oxygenation, until [DATE] at 2:29 AM when the paramedics pronounced Resident 77 dead after providing unsuccessful CPR (cardiopulmonary resuscitation, an emergency treatment for someone who stopped breathing or heartbeat has stopped by providing chest compression [pressing on the chest over the heart] and rescue breathing [mouth-to-mouth resuscitation]) was provided.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 2:02 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the facility's failure to notify the physician regarding significant changes in Resident 77's respiratory conditions and provide the necessary respiratory care and monitoring.</p> <p>On [DATE] at 11:17 AM, the IJ was removed in the presence of the Administrator (ADM) and the Director of Nurses (DON) after the facility submitted an acceptable IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) and while onsite at the facility, the surveyors verified/confirmed the facility's implementation of the IJ Removal Plan and the IJ situation was no longer present.</p> <p>The IJ Removal Plan dated [DATE], included the following:</p> <ol style="list-style-type: none"> On [DATE], the Director of Nursing (DON) conducted a full house audit to identify all residents with a diagnosis of COPD, those on continuous and, PRN (as needed) oxygen. The audit identified 10 residents with COPD and 18 residents receiving oxygen therapy. The DON reviewed the care plans and physician's orders for these residents to ensure appropriate interventions such as following MD (Medical Doctor/physician) orders, oxygen therapy orders, repositioning of patients, checking oxygen saturation, assessment of signs and symptoms of hypoxia (low blood oxygen in the body tissues) respiratory failure (failure of the lungs to meet the body's demand for oxygen) for effectiveness of the intervention and monitoring for signs and symptoms of respiratory distress, verifying respiratory status using objective data such as oxygen saturation were in place. The DON will also review the communication to the Primary Care MD, if no response, the medical director and or emergency services will be called immediately. No additional residents were found to be at immediate risk. On [DATE] a one to one in-service regarding MD notification, Medical Director notification, and emergency services was provided to the Night Shift Licensed Nurse assigned to Resident 77 on [DATE], by the facility's DON. The Licensed Nurse was also suspended pending the facility's investigation. On [DATE] and [DATE] the Pharmacy Consultant initiated Medication Regimen Reviews (review of the medications the residents are receiving) for all residents receiving Oxygen Therapy and with COPD/SOB. On [DATE], the facility conducted a root cause analysis (RCA) which included interviews with involved staff. The RCA revealed the following contributing factors: Lack of staff education on monitoring and reporting changes in respiratory status, and inadequate communication between nursing staff and physicians regarding significant changes in condition. On [DATE] the Certified Nursing Assistant (CNA) assigned to Resident 77 on [DATE] during the night shift was provided a one-to-one in-service regarding Emergency Care Policy and Procedure. <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>6. On [DATE], the Director of Nursing/ Staff Development Coordinator (DSD) started to provide in- services to all Licensed Nursing staff for all shifts including CNAs, LVNS, RNs on Emergency Medical Response: A. Monitoring and reporting changes in respiratory status B. Following physician orders for oxygen titration and maintaining target oxygen saturation levels, and C. Facility policy and procedure for responding to respiratory distress, including immediate notification of the primary physician, emergency services, and medical director.</p> <p>7. By [DATE], the DON reviewed the facility's policy and procedure for responding to respiratory distress to ensure clarity and consistency with current standards of practice.</p> <p>8. By [DATE], the DON created a monitoring tool related to COPD and Oxygen Therapy to ensure clarity and consistency with current standards of practice.</p> <p>Findings:</p> <p>During a review of Resident 77's Admission Record (AR), the AR indicated the facility admitted Resident 77 on [DATE] and readmitted on [DATE] with diagnoses that included COPD with exacerbation (worsened symptoms), pneumonia, hypertensive heart disease (high blood pressure), and type 2 diabetes mellitus (condition of having high blood sugar).</p> <p>During a review of Resident 77's Physician Orders for Life-Sustaining Treatment (POLST- a medical order that documents a patient's preferences for end-of-life care), dated [DATE], indicated if the resident was found with a pulse and/or was breathing, full treatment was ordered for medical interventions including intubation (a tube placed in the mouth to the airway to provide oxygenation), advanced airway interventions (a tube placed in the airway), mechanical ventilation (assisted breathing provided with the use of a machine), and cardioversion (a medical procedure that restores a normal heart rhythm by using electricity or medication to treat an abnormal heart rhythm).</p> <p>During a review of Resident 77's Order Summary Report (OSR), indicated on [DATE], Resident 77 had physician orders to monitor for sign and symptoms of respiratory distress that included monitoring for pulse oximetry (a device used to monitor oxygen blood level), lethargy (a state of unusual drowsiness, fatigue, and lack of energy and mental alertness), accessory muscle usage (breathing using muscles other than those typically used for breathing to take in and expel air) and to document with hashmarks (or tally marks, a numerical system used to keep track of things by number) in the clinical record of the resident if present and report to the physician. The physician also ordered to titrate (adjust) oxygen at , d+[DATE] L/min via NC continuously to maintain oxygen saturation at 92 % or above, and to notify the physician if oxygen saturation was below 92% for SOB. The OSR indicated in the event of an emergency, the Medical Director may be called if the attending physician or alternate physician are not available.</p> <p>During a review of Resident 77's History and Physical Examinations, dated [DATE], indicated Resident 77 had the capacity to understand and make decisions.</p> <p>During a review of Resident 77's OSR, indicated on [DATE], Resident 77 had a physician order for Full Code (a medical order that instructs the health care team to perform all possible life-saving measures if the resident goes into cardiac or respiratory arrest [when the heart stopped beating or the resident stopped breathing]).</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 77's Physician Progress Note, dated [DATE], indicated Resident 77 exhibited alertness and cognitive ability to effectively communicate needs and his language comprehension and response during assessments were appropriate. The notes indicated Resident 77 continued under monitoring for anemia (a condition of not having enough healthy red blood cells to carry oxygen to the body's tissues) and has declined hospitalization despite the recommendation, understanding the associated risks and benefits.</p> <p>During a review of Resident 77's Physician Progress Note, dated [DATE], indicated when confronted with acute medical symptoms or conditions necessitating immediate attention for Resident 77, the staff has received explicit instructions to promptly trigger emergency medical services (EMS- a system that provides emergency medical care to residents after an incident of serious illness or injury) via 911 and direct the resident to the emergency department. These symptoms and conditions encompass, though are not confined to exacerbation (severe symptoms) of asthma (a respiratory disorder that makes it difficult to breath). The note indicated, the data mentioned above is based on information available during the encounter and may change as other data becomes available.</p> <p>During a review of Resident 77's Care plan, dated [DATE], indicated Resident 77 had exacerbation (worsened symptoms) of COPD manifested by wheezing (a high-pitched, whistling sound that occur during breathing when the airways in the lungs become narrowed or blocked) with the goal that the resident would display optimal breathing patterns daily. The care plan interventions included to give aerosol (a substance released in very fine mist) or bronchodilations (a medication that make breathing easier by relaxing the muscles in the lungs and widening the airways [bronchi]) as ordered by the physician and monitor/document any side effects and effectiveness, to monitor for difficulty breathing on exertion, and to administer oxygen via nasal cannula at 2 L/min.</p> <p>During a review of Resident 77's OSR, indicated on [DATE], Resident 77 had a physician order for Ipratropium-Albuterol (a medication used to prevent wheezing, difficulty breathing, chest tightness, and coughing) 3 ml (milliliter, unit of volume) inhale (breathing in) orally (by mouth) every 6 hours as needed for SOB/wheezing for 14 days.</p> <p>During a review of Resident 77's Progress Notes, dated [DATE], indicated on [DATE] at 11:05 PM, during an initial assessment Licensed Vocational Nurse (LVN) 6 noted Resident 77 was in bed asleep but responsive to verbal stimuli with no complaint of pain or discomfort. The note indicated on [DATE] at 12:10 AM, Resident 77 was sitting on his bed and verbalized I can't breathe, I need a breathing treatment, breathing was labored with oxygen saturation was at 72%. The note indicated LVN 6 administered a breathing treatment and offered to transfer the resident to the hospital of which Resident 77 declined and on [DATE] at 12:30 AM, Resident 77 verbalized thank you, I'm feeling better. The note indicated at on [DATE] at 1 AM, Resident 77 was asleep with eyes closed and receiving continuous oxygen at 2 L/min, then at 1:55 AM, LVN 6 was alerted to Resident 77's room by Certified Nurse Assistant (CNA) 4, that Resident 77 was unresponsive with no chest movement and no pulse, CPR (cardiopulmonary resuscitation, is an emergency treatment that's done when someone's breathing or heartbeat has stopped by chest compression [pressing on the chest over the heart] and rescue breathing [mouth-to-mouth resuscitation]) was initiated and 911 was called. The notes indicated on [DATE] at 2:10 AM, the paramedics arrived and took over the CPR and Resident 77 was pronounced dead at 2:29 AM and Resident 77's physician was notified via text on [DATE] at 3:16 AM.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 77's Medication Administration Record (MAR) for [DATE], indicated on [DATE] at 12:10 AM, Ipratropium-Albuterol Inhalation Solution medication was given to Resident 77 for SOB/wheezing.</p> <p>During a review of Resident 77's Physician's Discharge Summary, dated [DATE], indicated Resident 77 was discharged from the facility due to resident expired.</p> <p>During a review of Paramedic Run Report, dated [DATE], indicated Resident 77 presented warm, pupils were fixed (indication of no brain activity), in asystole (no heart rhythm) and for the duration of CPR. The report indicated, Resident 77 remained in asystole with no changes after given 3 Epinephrine (the primary drug administered during CPR to reverse cardiac arrest) doses and was pronounced dead at 2:29 AM after 20 minutes of high-quality CPR. The report indicated, staff stated the patient (Resident 77) is being seen at this facility for COPD and possible pneumonia. Pt was advised to go to the hospital by staff numerous times for better care and treatment but declined for a week. Pt was given a breathing treatment by staff at midnight with no improvement and was found not breathing at around on [DATE] at 2 AM. Staff immediately began CPR and called 911. CPR taken over by EMS on [DATE] at 2:09 AM.</p> <p>During an interview on [DATE] at 4:37 PM with CNA 4, CNA 4 stated, when she came to work on [DATE] at around 11:06 PM, Resident 77 did not respond when she tried to greet him, his eyes were closed, and he was breathing very fast. CNA 4 stated, Resident 77 was receiving oxygen supplement with a tube in his nose. CNA 4 stated, LVN 6 told her that Resident 77 was not feeling well and that she should keep an eye on the resident. CNA 4 stated, she checked Resident 77 several times and observed Resident 77's breathing was getting loose and loose to the point of no breathing anymore, and his facial expression was flat. CNA 4 stated, she did not monitor for Resident 77's vital signs (measurement of the blood pressure, heart rate, respiratory rate, and body temperature) or oxygen saturation because it was the charge nurse's responsibility. CNA 4 stated, she asked LVN 6 to Please come and check on Resident 77 because she had to attend another resident. CNA 4 stated, LVN 6 went to see Resident 77 and she went to another resident's room to give care. CNA 4 stated, when she came out of the other resident's room, she saw LVN 4 bringing in a big oxygen tank to Resident 77's room. When she peeked in Resident 77's room, LVN 4 told her that the resident was dead. CNA 4 stated, she recalled LVN 4 was performing CPR on Resident 77, but she did not come to help in Resident 77's room because she was busy with the other resident.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 5:09 PM with LVN 6, LVN 6 stated, when he first checked on Resident 77 at the start of his shift on [DATE] at around 11 PM, Resident 77's vital signs including the oxygen saturation was around ,d+[DATE]% while Resident 77 was receiving 2 L/min oxygen via NC. LVN 6 stated, Resident 77 was breathing heavily, and very labored. LVN 6 stated, about an hour later, Resident 77 told him I can't breathe, I want my breathing treatment. LVN 6 stated he checked Resident 77's oxygen saturation and it was at 72%. LVN 6 stated, he asked Resident 77 if he wanted to be transferred to the hospital, but Resident 77 stated No, meaning he didn't want to go the hospital, so LVN 6 gave Resident 77 Albuterol breathing treatment as ordered by the physician. LVN 6 stated, after the treatment, Resident 77's oxygen saturation went up, but not that high, to ,d+[DATE]%. LVN 6 stated, he asked Resident 77 again if Resident 77 wanted to be transferred to the hospital, Resident 77 stated No. LVN 6 stated, after the breathing treatment was given, he put Resident 77 back to continuous oxygen at 3 L/min via NC. LVN 6 stated, he did not recheck Resident 77's vital signs when Resident 77 had an episode of decreased oxygen saturation of 72%, and he did not recheck and monitor Resident 77's oxygen saturation after giving Resident 77's breathing treatment when the oxygen saturation increased to ,d+[DATE]%. LVN 6 stated, when communicating with the physicians at the facility, the staffs only text the doctors during the night, the staffs do not call the doctors if they need to report the resident's condition. LVN 6 stated, he did not document Resident 77's (Change of Condition) COC, notify the doctor via text or call, or call 911 regarding Resident 77's labored breathing, low oxygen level, changes in the respiratory and refusal to go to the hospital because Resident 77 had a behavior of refusing to be transferred to the hospital and because LVN 6 believed that Resident 77's breathing was better given that the oxygen saturation went up from 72 % to ,d+[DATE]%. LVN 6 also stated, he was busy with other residents. LVN 6 stated, he told CNA 4 to keep an eye on Resident 77 for his movement in case Resident 77 was not breathing. LVN 6 stated, when CNA 4 came and told him to come to see Resident 77, he rushed in Resident 77's room, tapped on Resident 77's shoulder but the resident was not responding. LVN 6 stated, Resident 77's chest was not moving up and down, so he ran out of the room to call for help and brought in the bigger oxygen tank. LVN 6 stated, LVN 7 was helping him to call 911 while he went back to Resident 77's room and started CPR. LVN 6 stated, the resident's room did not have any button to activate Code Blue (a code announced through an overhead audio system to alert the staffs in the facility about a medical emergency). LVN 6 stated, he did not call for a Code Blue overhead because he did not want to panic other residents during the nighttime.</p> <p>During an interview on [DATE] at 6:06 PM with LVN 7, LVN 7 stated, he was at his nursing station when he heard LVN 6 running in the hallway, telling him, My patient is not responding. LVN 7 stated, he helped LVN 6 to call 911 at his station, when he finished his call with 911, he walked over to Resident 77's room and believed that there were two to three people in the room and recalled one of them was doing CPR. LVN 7 stated, he did not come in to help because the EMS already came in by that time.</p> <p>During a concurrent record review and interview on [DATE] at 9:14 AM with the Regional Medical Record (RMR), Resident 77's Change of Condition/MD notification and orders for the month of [DATE] were reviewed. The RMR stated, there was no documented evidence that a COC was completed, no indication that the physician was notified, and no physician order to address Resident 77's respiratory distress and decreased oxygenation on [DATE]. The RMR stated, there was no care plan for Resident 77's refusal to go to the hospital and no documented evidence that alternative interventions were discussed with Resident 77 regarding his refusal. There was also no documentation that the DON, Administrator or the facility's Medical Director was informed about Resident 77's change in respiratory condition.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:04 AM with the MDS Nurse (MDSN), the MDSN stated, when Resident 77 desaturated (a drop in blood oxygen level) and was having SOB, LVN 6 should follow the doctor's order to notify the doctor right away about the situation and the resident's low saturation even when the resident refused to be transferred to the hospital. The MDSN stated, the doctor should be notified about the resident's refusal because if the resident was alert enough, the doctor could explain to the resident that if he refused care, it could lead to death. The MDSN stated, it was important to notify the doctor right away so the LVN could have orders for immediate interventions and treatment. The MDSN stated, the doctor might also ask the nurse to just call 911.</p> <p>During an interview on [DATE] at 11:16 AM with the Director of Nurses (DON), the DON stated, at nighttime, the facility doesn't have any registered nurse, only LVNs. The DON stated, depending on the severity of the situation, the doctor could be contacted via calls or text messages. The DON stated, if the primary physician didn't respond, the medical director could be notified. The DON stated, he (DON) was also available , d+[DATE] in case of emergency for guidance. The DON stated, in a situation when the resident's saturation went down to 72% and was having SOB and there was order for breathing treatment, the nurse could send the doctor a text to notify the doctor about the situation. The DON stated, while waiting for the doctor's response, the LVN should monitor for the resident's vital signs including oxygen saturation, put the resident on oxygen and titrate to the maximum oxygen level as ordered, give breathing treatment, and continue to monitor the resident for how the resident was doing with vital signs and document them in the resident's medical record. The DON stated, if the oxygen saturation was at ,d+[DATE]% after treatment, the treatment was not effective. The DON stated, if the resident refused to be transferred to the hospital, the nurse should notify the doctor right away to report the situation that the oxygen and breathing treatment was given as ordered but the oxygen saturation level did not increase as expected and that the resident refused transferring to the hospital. The DON stated, LVN 6 should have reported Resident 77's desaturation episode and his refusal to the doctor even if LVN 6 respected Resident 77's right and have the doctor decide what to do. The DON stated, 911 should have been called to manage the situation.</p> <p>During an interview on [DATE] at 4:50 PM with Resident 77's primary physician (PMP 1), the PMP 1 stated, on the night of [DATE], he did not receive any text or call from the facility staff regarding Resident 77's desaturation and SOB. PMP 1 stated, he only got a text to notify him that his patient (Resident 77) had passed away early morning of [DATE] because of unresponsiveness and not breathing. PMP 1 stated, when the oxygen saturation went down to 72% and Resident 77 was having SOB, LVN 6 should give breathing treatment and notify him at least via text messages. PMP 1 stated, after breathing treatment, when the oxygen saturation went up to ,d+[DATE]%, the saturation was still too low, and Resident 77 should have been transferred out to the hospital for higher level of care. PMP 1 stated, even when Resident 77 refused, LVN 6 should have let him know. PMP 1 stated, he would have asked LVN 6 to transfer or call 911. PMP 1 stated, the facility's practice is very aggressive with transferring out in cases of emergency that the patient was not able to be stabilized. PMP 1 stated, if he was aware of the patient's repeated refusal to care, he would consider hospice or discuss with him of changing in code status if Resident 77 was alert able to decide for himself. PMP 1 stated, LVN 6 should not decide by himself without informing the physician whether to not transfer Resident 77 to the hospital or not due to respecting the resident's right because Resident 77 was still a full code.</p> <p>During a review of the facility's Policies and Procedures (P&P) titled, Change of Condition (COC) Notification, revised [DATE], indicated the following:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Glenoaks Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 409 W. Glenoaks Blvd. Glendale, CA 91202	
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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a. An acute COC is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. Clinical important means a deviation that, without intervention, may result in complications or death.</p> <p>b. The Licensed nurse will notify the resident's Attending Physician when there is a significant change in the resident's physical, mental or psychosocial status, e.g., deterioration in health, life threatening conditions or clinical complications; a need to alter treatment signification; and a decision to transfer or discharge the resident from the facility.</p> <p>c. The Licensed Nurse will assess the resident's COC and document the observations and symptoms.</p> <p>d. The Attending Physician will be notified timely with the residents' COC. Notification to the Attending Physician will include a summary of the condition change, and an assessment of the resident's vital signs.</p> <p>e. In emergency situations (e.g., a resident is experiencing unexpected SOB), the Licensed Nurse will: immediately call the Attending Physician.</p> <p>f. If the Licensed Nurse is unable to reach the Attending Physician or the Physician on call during emergency situations, he/she will notify the Facility's Medical Director. If the resident deteriorates, the symptoms are serious, and the most rapid intervention available by a physician would place the resident in great jeopardy, call 911 for transport to hospital.</p> <p>g. Notify the Nursing Supervisor of emergency.</p> <p>During a review of the facility's P&P titled, Emergency Care - General, revised [DATE], indicated, emergency - Life threatening is the situation that requires prompt intervening actions to maintain physical, mental, and/or emotional health. Summon help and immediately call 911 for medical emergency assistance. These emergency situations would include but are not limited to: cessation (stop) of breathing and document the resident's vital signs including blood pressure, pulse, respirations and temperature.</p> <p>During a review of the facility's P&P titled, Pulse Oximetry (Assessing Oxygen Saturation), revised [DATE], indicated:</p> <p>a. For the safety and comfort of residents, the Facility will utilize pulse oximetry to measure levels of oxygen in the resident's blood when such measurement is ordered by the resident's Attending Physician or as indicated by the resident's condition.</p> <p>b. A normal oxygen saturation is between 90 to 100 percent. Anything below 90 percent should be closely monitored, including the maintenance of a flow chart or documentation record for oxygen saturation level.</p> <p>c. Residents with respiratory distress will have a respiratory assessment completed that may include the use of a pulse oximeter to noninvasively measure the resident's blood oxygen saturation.</p> <p>d. If oxygen saturation is less than 90 percent, if oxygen saturation is at less than an acceptable level fo the resident's condition, notify the Attending Physician.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P titled, Oxygen Administration, dated [DATE], indicated to prevent or reverse hypoxia and provide oxygen to the tissues, the facility will, in an emergency situation or when a physician's order cannot be immediately obtained, oxygen may be initiated by a Licensed Nurse in the presence of acute chest pain or any other acute situation in which hypoxia is suspected. A physician is to be contacted as soon as possible after initiation of oxygen therapy in emergency situations, for verification and documentation of the order for oxygen therapy consultation, and further orders. Oxygen saturations will be measured and documented at a minimum of daily for resident's receiving oxygen therapy.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012</p> <p>Based on interview and record review, the facility failed to ensure that Licensed Vocational Nurse (LVN) 6 had the appropriate competencies and skills set to provide nursing care, which included assessing, evaluating, intervening timely and responding to one of three sampled residents (Resident 77) experiencing respiratory distress (trouble breathing often having to work harder to breathe or are not getting enough oxygen) associated with COPD.</p> <p>This failure resulted in the resident condition to decline and resulted in death.</p> <p>Cross reference to F695 and F580</p> <p>Findings:</p> <p>During a review of Resident 77's Admission Record, the facility admitted Resident 77 on [DATE] and readmitted Resident 77 on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, a chronic lung disease causing difficulty in breathing) with acute exacerbation and pneumonia.</p> <p>During a review of Resident 77's Physician Orders for Life- Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end of life), dated [DATE], the POLST indicated Resident 77 wished to have Cardiopulmonary Resuscitation (CPR, emergency procedure that involves chest compression and rescue breath like mouth to mouth breathing performed when a person's breathing or heartbeat has stopped).</p> <p>During a review of Resident 77's Order Summary Report (instructions that communicated the medical care that the resident received while in the facility), an order with a start date of [DATE], indicated in an event of an emergency, the Medical Director may be called if the attending physician or alternate physician are not available.</p> <p>During a review of Resident 77's Order Summary Report, an order with a start date of [DATE], the order indicated to titrate Resident 77's oxygen (colorless and odorless gas needed for life) between ,d+[DATE] liters per minute (LPM, unit of measure) via nasal cannula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) continuously to maintain oxygen levels above 92%. The order indicated to notify the physician if oxygen saturation levels (normal oxygen levels is between , d+[DATE]%) were less than 92%, every shift for shortness of breath.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 77's Order Summary Report, an order with a start date of [DATE], the order indicated to monitor for signs and symptoms of respiratory distress which included respirations, pulse oximetry (non-invasive way to measure oxygen levels in the blood), increased heart rate, restlessness, diaphoresis (excessive sweating), headaches, lethargy (state of unusual drowsiness anergy and mental alertness), confusion, atelectasis (a collapse of an area of the lung), hemoptysis (coughing up blood), cough, pleuritic pain (sharp chest pain when breathing or coughing), accessory muscle usage, and skin color. The order indicated to document the signs and symptoms with hashmarks if monitored and report to the physician.</p> <p>During a review of Resident 77's Nursing Progress Notes (a written record that a nurse keeps about a resident's health status), dated [DATE] written by LVN 6, the progress note indicated the following:</p> <p>At 11:05PM - Resident 77 was sleeping in bed but responsive to verbal stimuli.</p> <p>At 12:10AM - Resident 77 stated I cannot breathe. I need a breathing treatment. Resident 77 had increased work of breathing, and his oxygen levels were 72%. LVN 6 administered a breathing treatment. LVN 6 offered to transfer Resident 77 to the GACH but Resident 77 declined.</p> <p>At 1:00AM - Resident was asleep with his eyes closed on continuous supplementary oxygen at 2 LPM.</p> <p>At 1:55AM - LVN 6 was alerted to Resident 77's by Certified Nurse Assistant (CNA) 4 and found Resident 77 unresponsive, no chest movement, and no pulse.</p> <p>At 3:16AM - the physician was notified by text message that Resident 77 expired.</p> <p>During a telephone interview on [DATE] at 4:37PM with CNA 4, CNA 4 stated, Resident 77 was not responsive to him, Resident 77's eyes were closed, and Resident 77 was breathing very fast. CNA 4 stated that LVN 6 reported to him that Resident 77 was not feeling well and that he (CNA 4) should keep an eye on him (Resident 77).</p> <p>During a telephone interview on [DATE] at 5:09PM with LVN 6, LVN 6 stated, Resident 77 was on 2 liters of continuous oxygen via NC, and his breathing was very labored. LVN 6 stated, he asked Resident 77 if he wanted to go to the hospital, and Resident 77 denied. LVN 6 stated, he gave Resident 77 a breathing treatment because his oxygen level was at 72%. LVN 6 stated, after the breathing treatment, his oxygen levels went up to ,d+[DATE]%, and Resident 77 continued to refuse to be transferred to the hospital. LVN 6 stated, he told CNA 4 to monitor Resident 77 in case he was not breathing. LVN 6 stated, he does not remember if he called the doctor and did not complete a CoC because it happened so fast. LVN 6 stated, CNA 4 called him to Resident 77's room, and tapped his (Resident 77's) shoulder. He was not responding, and his chest was not moving up and down. LVN 6 stated, he ran out of Resident 77's room to call for help and get the oxygen tank. LVN 6 stated, the nurses do not call the physicians at night; the nurses text him during the night. LVN 6 stated, he did not call the physician because Resident 77 had a known behavior of refusing to be transferred to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:04 AM with the Minimal Data Set Nurse (MDSN), the MDSN stated when a resident has low oxygen levels, the nurse should complete a CoC and notify the physician. The MDSN stated, the physician should be notified of Resident 77's shortness of breath, low oxygen levels, and refusal to be transferred to the hospital. The MDSN stated, it was important for the nurse to notify the physician of an emergency right away for proper care and treatment for the resident.</p> <p>During a phone interview on [DATE] at 11:16AM with the Director of Nursing (DON), the DON stated, there was no Registered Nurse (RN) during the nighttime only during the morning and afternoon shift. The DON stated, the nurse can call the physician or send a text message depending on the severity of the situation. The DON stated, if the primary physician cannot be reached, the facility's medical director should be notified. The DON stated, he was available 24-hours/7days a week as well. The DON stated, if a resident's oxygen levels went down to 72%, the LVN should have notified the physician about the resident's findings. The DON stated, there should have been continuous monitoring and assessment of Resident 77, and if there was an order, titrate (increase or decrease levels) the oxygen levels to the max oxygen level. The DON stated, if the resident refused to be transferred to the hospital, the nurse should notify the physician again about the situation and let the physician decide what he wants to do.</p> <p>During a phone interview on [DATE] at 4:50 PM with Resident 77's Primary Physician (PMP) 1, PMP 1 stated, he did not receive any text message or phone call the night of [DATE] about Resident 77's condition. PMP 1 stated, he received a text message the morning of [DATE] that Resident 77 had passed away due to being unresponsive. PMP 1 stated, even if Resident 77's oxygen levels went up to ,d+[DATE]% after a breathing treatment and he continued to say no to transfer, Resident 77 should have been transferred out. PMP 1 stated, the nurse should discuss with the doctor about a resident's decision and should not decide whether a resident should be transferred to the hospital.</p> <p>During a review of the facility's policies and procedures (P&P), Care and Services, dated [DATE], the P&P indicated the facility will have sufficient staff to provide services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being.</p> <p>During a review of the facility's P&P, Care Standards, dated [DATE], the P&P indicated the DON should ensure care and services are delivered according to accepted standards of clinical practice. The P&P indicated the authoritative resources for clinical standards of practice include but are not limited to:</p> <ol style="list-style-type: none"> 1. State practice acts for specific credentials 2. Lippincott's Manual of Nursing Practice Ninth Edition 3. Lippincott's Nursing Procedures Sixth Edition 4. American Medical Association 5. American Nursing Association <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's job description, Charge Nurse, date unknown, the job description indicated the Charge Nurses should consult with the resident's physician in providing the resident's care, treatment, rehabilitation, etc., as necessary. The job description indicated, the Charge Nurse should implement and maintain established nursing objectives and standards. The job description indicated, the Charge Nurse should notify the resident's attending physician when the resident is involved in an accident or incident, and should notify the resident's attending physician and next-of-kin when there is a change in the resident's condition.</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>50203</p> <p>Based on observation, interview, and record review, the facility failed to ensure the nurse staffing information was posted in a highly visible and prominent place that was readily accessible to residents, staff, and visitors daily.</p> <p>This failure had the potential to result in residents and visitors not being able to access full view the facility's staffing information to ensure safe staffing sufficient staffing were implemented.</p> <p>Findings:</p> <p>During an observation on 12/3/2024 at 8:30AM in the front lobby, there was no nurse staffing information posted by the receptionist's desk.</p> <p>During an observation on 12/3/2024 at 9:00AM in Nursing Station 1, 2, and 3, there was no nurse staffing information posted with each Nursing Station.</p> <p>During a concurrent observation and interview on 12/6/2024 at 6:50 PM with the Director of Staff Development (DSD), the facility's nurse staffing information was posted next to the facility's shadow box frame by the main entrance that contained important facility documents not limited to the facility's business license and administrator's license, not easily visible to residents and visitors. The DSD stated, the nurse staffing information should be posted in a highly visible area so the residents and visitors could see the projected numbers of Certified Nurse Assistants (CNAs) would be working that day and how many CNAs will be caring for the facility's residents.</p> <p>During an interview on 12/6/2024 at 7:30PM with the Director of Nursing (DON), the DON stated, nurse staffing information was not posted in a highly visible area such as the nursing station or by the front lobby. The DON stated, it was important to have the nurse staffing information posted in a prominent place so all the residents and family members can see and have the assurance that there was enough staff taking care of their loved one on any day in the facility.</p> <p>During a review of the facility's policies and procedures (P&P), Nursing Department - Staffing, Scheduling, & Posting, revised on 10/24/2022, the P&P indicated the nurse staffing data must be posted in a clear and readable format and in a prominent place readily accessible to residents and visitors.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012</p> <p>Based on observations, interviews, and record reviews, the facility failed to implement appropriate behavior management and interventions to address the resident's behavioral of agitation, yelling, and attempts to hit staff for one of 2 sampled residents (Resident 16) by failing to:</p> <p>Ensure that care and services were person-centered, aligned with the resident's goals, and maximized their dignity, autonomy, privacy, socialization, independence, choice, and safety.</p> <p>Ensure direct care staff did not consistently interact and communicate in ways that supported the resident's mental and psychosocial well-being.</p> <p>This deficiency could have the potential to result in the failure to implement appropriate behavior management interventions to address the resident's behavioral challenges and support their mental and psychosocial well-being.</p> <p>Findings:</p> <p>During a review of Resident 16 ' s Admission Record (Face Sheet), dated 12/4/2024, the face sheet indicated the facility admitted Resident 16 on 5/14/2014, and readmitted on [DATE] with diagnoses including epilepsy (a brain disorder that can cause people to suddenly become unconscious and have violent, uncontrolled movements of the body), and intellectual disabilities.</p> <p>During a review of Resident 16 ' s History and Physical (H&P), dated 6/27/2024 indicated, Resident 16 does not have the mental capacity to make medical decisions.</p> <p>During a review of Resident 16's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/29/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and needed supervision to extensive assistance from the staff for the activities of daily living.</p> <p>During an observation on 12/3/2024 at 11:55 AM, Resident 16 was walking in the hallway wearing a long t-shirt without pants covering her private area. A Certified Nurse Assistant 4 (CNA 7) was observed redirecting Resident 16 back to her room by holding her by the shoulders as the resident yelled in in a foreign language saying to leave her alone. Resident 16 ' s repeatedly attempted to walk back to the hallway and continued to yell to be left alone, CNA 7 maintained physical contact and attempted to redirect her, saying, Let ' s go back to your room; you have no pants on. Let ' s dress you. CNA 7 did not release Resident 16 when she expressed her desire to be left alone. Resident 16 was held by the shoulder by CNA 7 and went back in the room. Then CNA 7 closed the door after they entered the room.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/3/2024 at 2:00 PM with the Certified Nurse Assistant (CNA 7), the CNA 7 stated that she attempted to calm Resident 16 and return her to her room because her body was exposed after removing her diaper. CNA 7 stated she did not seek help from other nurses, as they were busy, and she felt the task needed to be handled alone. CNA 7 stated that assisting Resident 16 by holding her shoulders and guiding her back to the room made the resident more agitated and the resident scratched her during the process. CNA 7 stated that her intention was to protect the resident ' s dignity and privacy.</p> <p>During an interview on 12/3/2024 at 2:15 PM with the License Vocational Nurse 2 (LVN 2), the LVN 2 stated the CNA 7 should have worked to de-escalate the situation by using a calmer approach. LVN 2 stated that if the CNA 7 had requested assistance, staff would have stepped in to help. LVN 2 stated, the resident usually calms down when staff talk to her and gently encourage her to return to her room. LVN 2 stated the importance of respecting the resident's rights, stating, If the resident says not to touch her and leave her alone, I will not continue to touch her until she calms down. It ' s important to respect her wishes and not touch her while she is saying not to. LVN 2 stated that the resident does tend to hit staff at times, physical intervention should only occur when necessary and after efforts to calm the resident verbally have been made.</p> <p>During an interview on 12/3/2024 at 3:38PM with the Director of Nursing (DON), the DON stated in handling the situation with Resident 16, CNA 7 should have used verbal and non-verbal de-escalation techniques, such as cues, to manage agitation or aggression in residents. In addition, the CNA should ensure the resident ' s safety is always the primary goal. DON stated that the CNA should not have physically forced the resident into the room or closed the door against the resident's will, as this violated the resident ' s rights to privacy and respect. DON stated Resident 16 must be allowed time and space to calm down without being physically chased, as this may increase agitation and create safety risks. DON stated that CNA 7 should have call for help if they cannot manage the situation, using appropriate methods to ensure the resident remains calm. DON stated that forcing the resident after she expressed a clear desire not to be touched is unacceptable and constitutes a violates Resident 16 rights.</p> <p>During a review of Resident 16's Order Summary Report, dated 12/4/2024, the Order Summary Report indicated an order on 10/15/2024/ psych consult due to agitation, screaming/yelling, and attempting to hit staff.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Behavior-Management, revised 11/01/2017, indicated the facility will ensure that Facility Staff performs an appropriate assessment of the resident's behavioral symptoms and implement appropriate interventions before and after the resident begins ??a king psychotherapeutic medication.</p> <p>When a resident displays adverse behavioral symptoms (e.g., crying, yelling, hitting, resisting care, etc.), licensed Nursing Staff will assess the behavioral symptoms to determine possible causal factors, contact the Attending Physician, and implement non-drug interventions to alleviate the behavioral symptoms before initiating any psychotherapeutic agent(s).</p> <p>The facility must provide necessary behavioral health care and services which include:</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensuring that the necessary care and services are person-centered and reflect the resident ' s goals for care, while maximizing the resident ' s dignity, autonomy, privacy, socialization, independence, choice, and safety.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012</p> <p>Based on interviews and records review, the facility failed to ensure one of three residents (Resident 16) was free from unnecessary medications by failing to ensure the resident does not receive Ativan (a medication used to relieve anxiety (severe fear of the unknown) by failing to document the justification for the continued use of Ativan PRN (as needed) beyond the 14-days limit.</p> <p>These deficiencies have the potential to result in the use of unnecessary medication, that could lead to adverse reaction (undesired outcome of the medication use).</p> <p>Findings:</p> <p>During a review of Resident 16 ' s Admission Record (Face Sheet), dated 12/4/2024, indicated the facility admitted Resident 16 on 5/14/2014, and readmitted on [DATE] with diagnoses that included seizures/epilepsy (a brain disorder that can cause people to suddenly become unconscious and have violent, uncontrolled movements of the body), and intellectual disabilities (a developmental disorder that affects a person's ability to learn and function in daily life).</p> <p>During a review of Resident 16 ' s History and Physical (H&P), dated 6/27/2024 indicated, Resident 16 does not have the mental capacity to make medical decisions.</p> <p>During a review of Resident 16's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/29/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and needed supervision to extensive assistance from the staff for the activities of daily living.</p> <p>During a review of Resident 16's Order Summary Report, dated 12/4/2024, the Order Summary Report indicated the physician ordered on 12/15/2023 to give Resident 16 Ativan (Lorazepam- antianxiety medication also used for seizures) 1 milligrams (mg) one tablet by gastrostomy tube (GT - an opening to the stomach from the abdominal wall made surgically for the introduction of food or medication) every four (4) hours as needed for seizures and to give Lorazepam injection solution 2mg/ milliliters (ml) inject 1 mg intramuscular every 12 hours as needed for anxiety related to Epilepsy. Ativan (Lorazepam)PRN (as needed).</p> <p>During an interview on 12/6/2024 at 5 PM with the Director of Nursing (DON) who stated the physician's order for Ativan PRN was not limited to 14 days use only. DON stated he plans to contact the physician to verify the PRN order and stated that the resident might require reevaluation.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Psychotherapeutic Drug Management revised 2022, indicated that PRN orders for psychotropic drugs are limited to 14 days. If the Attending Physician/LHP 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.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36925</p> <p>Based on observation, interview, and record review, the facility failed to administer medications to two of three sampled residents (Resident 45 and Resident 61) as prescribed by the physician during a medication administration observation that resulted in 7.14 % medication error rate by failing to ensure:</p> <ol style="list-style-type: none"> 1. Resident 45 was administered vitamin D3 (a vitamin supplement to help prevent bone disorders) oral (given by mouth) tablet 25 micrograms (unit of measurement) via G-tube (a small, flexible tube that's inserted through the stomach wall and into the stomach to deliver nutrition, fluids, and medicine) to 2. Resident 61 was administered multivitamin supplement oral (given by mouth) tablet by mouth. <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 45 ' s Admission Record indicated that the facility admitted the resident on 8/3/2021 and readmitted the resident on 3/7/2024 with diagnoses that included vitamin D deficiency (a deficiency of not getting enough vitamin D to stay healthy). <p>A review of Resident 45 ' s Minimum Data Set (MDS - a resident assessment tool), dated 11/4/2024, indicated that the resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired.</p> <p>During a medication administration observation on 12/4/2024 at 9:05 AM, Licensed Vocational Nurse (LVN) 1 administered a total of nine (9) medications to Resident 45 via G-tube.</p> <p>A review of Resident 45 ' s medical record titled; Order Summary Report indicated that the physician ordered on 9/27/2023 to administer Vitamin D3 oral tablet 25 micrograms for supplement via G-tube to the resident every morning.</p> <p>During an interview with LVN 1 on 12/4/2024 at 12:27 PM, she stated that she missed giving Vitamin D3 oral tablet to Resident 45 during the medication administration observation because she accidentally checked off Vitamin D3 as administered in the resident ' s electronic Medication Administration Record (e-MAR) when she was reviewing the scheduled medications of the resident.</p> <ol style="list-style-type: none"> 2. A review of Resident 61 ' s Admission Record indicated that the facility admitted the resident on 11/3/2023 and readmitted the resident on 4/25/2024 with diagnoses that included metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood that affects brain function). <p>A review of Resident 61 ' s MDS, dated [DATE], indicated that the resident ' s cognition was intact.</p> <p>During a medication administration observation on 12/4/2024 at 10:16 AM, LVN 1 administered a total of eight (8) medications to Resident 61 by mouth.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 61 ' s medical record titled; Order Summary Report indicated that the physician ordered on 10/10/2024 to administer a multivitamin oral tablet to be given by mouth one time a day for supplement.</p> <p>During an interview with LVN 1 on 12/4/2024 at 12:32 PM, she stated that she failed to administer the multivitamin oral tablet to Resident 61 because the Multivitamin did not populate (to add data to a table automatically) in the computer when she checked the medications that were scheduled for the resident.</p> <p>A review of the facility ' s undated policy titled, Medication - Administration version 1.0, revised on 6/1/2017, indicated that medications should be administered by a licensed nurse per the order of an attending physician or a licensed independent practitioner.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36925</p> <p>Based on observation, interview, and record review, the facility failed to safely and properly store medications and biologicals that were labeled and not expired in one of two medication cart and one on one medication room observed in accordance with the facility ' s policy and procedure titled Medications Storage in the Facility by failing to:</p> <ol style="list-style-type: none"> 1. Remove thirteen (13) pieces of expired Tylenol Suppositories (a pain reliever and fever reducer medication that is designed to be inserted into the anus) from the shelf in the Medication Storage Room in Station 1. 2. Remove an expired container filled with Ondansetron HCL (a drug to treat nausea and vomiting) oral tablet 4 milligrams (unit of mass) from the Medication Cart 2. 3. Remove nine (9) pieces of expired N95 face masks (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of diseases acquired from the air) from the Medication Cart 2. 4. Label an opened Lidocaine cream (a medication to treat pain) with an open date. <p>These deficient practices had the potential to cause medication errors, decreased medication potency to treat disease or relieve symptoms of a disease and expose the residents to adverse reactions (an undesired harmful effect) that could lead to serious harm or death.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 24 ' s Admission Record indicated that the facility admitted the resident on 12/11/2018 with diagnoses that included muscle weakness and hypokalemia (a condition where the amount of potassium [a mineral that the body needs to work properly] in the blood is lower than normal). <p>A review of Resident 24 ' s Minimum Data Set (MDS - a resident assessment tool), dated 11/16/2024, indicated that the resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was intact.</p> <p>A review of Resident 24 ' s medical record titled; Order Summary Report indicated that the physician made an order on 9/25/2023 to give one tablet of Ondansetron HCL oral tablet 4 milligrams by mouth to the resident every six hours as needed for nausea or vomiting.</p> <ol style="list-style-type: none"> 2. A review of Resident 62 ' s Admission Record indicated that the facility admitted the resident on 11/5/2024 with diagnoses that included encephalopathy (a general term for a group of conditions that cause brain dysfunction). <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 62 ' s MDS, dated [DATE], indicated that the resident ' s cognition was moderately impaired.</p> <p>A review of Resident 62 ' s medical record titled; Order Summary Report indicated that the physician made an order on 11/5/2024 to apply Lidocaine external cream 5% to the resident ' s knee three times a day for pain.</p> <p>During an observation on 12/4/2024 at 2:34 PM, thirteen (13) pieces of expired Tylenol suppositories were found on a shelf in the Medication Storage Room in Station 1. Four (4) of the 13 suppositories expired in 6/2024, six (6) pieces expired in 11/2024, and three (3) pieces expired in 12/2024.</p> <p>During an observation on 12/4/2024 at 3:07 PM, the following items were found in Medication Cart 2:</p> <p>A container filled with Ondansetron HCL oral tablet 4 milligrams that belonged to Resident 24, expired on 11/30/2024.</p> <p>Nine pieces of N95 face masks expired on 6/18/2022.</p> <p>An opened Lidocaine cream belonging to Resident 62 did not have an open date label.</p> <p>During a concurrent interview with Licensed Vocational Nurse (LVN) 4, she stated that the licensed nurses remove expired medications from the medication cart when they have time. LVN 4 stated that the pharmacist routinely comes over to the facility and removes expired medications when they inspect the medication carts and medication storage rooms.</p> <p>During an interview on 12/6/2024 at 8:31 AM, the Director of Nursing (DON) stated that the licensed nurses should routinely check, every shift, the expiration dates of the medications and supplies in the medication storage rooms and the medication carts. The DON stated that a system was in place where the charge nurses do a weekly revisit on each resident's profile to ensure that the resident's medication was not expired. The DON stated that the charge nurses most likely did not see the expired medications and expired supplies during the weekly audit. The DON stated that licensed nurses should put an open date label on a medication that has been opened as indicated in the facility ' s policy and in-service guidelines, since opening the medication may shorten the expiration date of the medicine.</p> <p>A review of the facility ' s undated policy titled; Medications Storage in the Facility revised in 1/2018, indicated that medications and biologicals should be stored safely, securely, and properly. When the original seal of a manufacturer ' s container or vial is initially broken, the nurse should place a date opened sticker on the medication and enter the date opened and the new date of expiration. All expired medications should be removed from the active supply and destroyed in the facility regardless of amount remaining.</p>

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48481</p> <p>Based on observation, interview and record review, the facility failed to provide one out of 3 sampled residents (Residents 76) with drinks that accommodated the resident ' s preferences.</p> <p>This deficient practice had the potential to result in decreased fluid intake and can lead to dehydration (not having enough fluid in the body).</p> <p>Findings:</p> <p>During an interview on 12/3/24 at 10:40 AM with Resident 76 regarding food service, Resident 76 stated I have told staff again and again, dietary staff would visit me and I would repeat what I don't want, I don't eat cheese, milk, pork or beef, but I'm still getting that.</p> <p>During an observation on 12/3/24 at 11:55 AM in the kitchen, tray card for Resident 76 indicated No beef. No Pork. No cheese. No milk.</p> <p>During a review of Resident 76 ' s Admission Record, Resident 76 was admitted on [DATE] with diagnoses that include spondylosis (a condition in which there is abnormal wear on the cartilage and bones of the neck) and primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of left and right hands.</p> <p>During a review of Minimal Data Sheet (MDS- a federally mandated resident assessment tool) dated 8/28/24 indicated that Resident 76 cognition is moderately impaired (short-term memory is more affected, significant difficulty with memory, reasoning, problem-solving, and daily tasks, including confusion, trouble following conversations, and challenges managing complex situations.)</p> <p>During a review of H&P dated 8/25/24 indicated that Resident 76 has early dementia (a progressive state of decline in mental abilities.)</p> <p>During a review of Physician Orders dated 11/26/24, the Physician Order indicated No added salt diet, mechanical soft texture, thin consistency. No pork, no beef, no milk no cheese per resident request.</p> <p>During a review of Care Plan dated 11/26/24 indicated interventions that included Encourage food intake as needed; Adhere to food preferences.</p> <p>During an observation on 12/5/24 at 2:05 PM at Resident # 76 ' s room, observed his lunch tray at bedside with plate and bowl were empty, a glass of milk on the tray was observed. Resident stated he liked the food for breakfast and lunch, but not know why milk was sent to him and stated would not drink it.</p> <p>(continued on next page)</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/5/24 at 2:20 PM with the Certified Dietary Manager (CDM) at Resident 76 ' s bedside, CDM read the tray card that indicated No milk and other items, stated aware of the resident ' s food preference, So this is not right, did not respond to the question why milk was provided to Resident 76.</p> <p>During a phone interview on 12/6/24 at 10AM with the Registered Dietitian (RD), the RD stated, Sufficient drinks are provided by the facility according to residents ' hydration needs, and their preferences and choices should be honored.</p> <p>During a review of the facility ' s policy and procedure titled, Resident Preference Interview dated 6/1/17, indicated, The Dietary Department will provide residents with meals consistent with their preferences as indicated on the tray card.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012</p> <p>Based on observation, interview and record review the facility failed to develop a system to systemically identify adverse events (a harmful and negative outcome that happens due to improper medical care), monitor, investigate, analyze root cause, implement and evaluate its Quality Assurance and Performance Improvement Program (QAPI, a program that is focused on action plan to correct identified quality deficiencies [a deviation in performance resulting in an actual or potential undesirable outcome, or an opportunity for improvement]) related to respiratory care for one of three sampled residents (Resident 77).</p> <p>Resident 77 ' s change of condition that led to resident ' s death was not investigated, analyzed of the root cause, to determine if the resident ' s death was a result of the facility ' s staff to notify the physician and emergency services, follow oxygen orders, monitor, and document the resident ' s condition, and respond appropriately to severe respiratory distress.</p> <p>As a result of this deficient practice, Resident 77 experienced respiratory distress and expired at the facility. This deficient practice could also result in the residents with respiratory diseases not to receive the quality of care needed to relieve respiratory distress.</p> <p>Cross reference to F695 and F580</p> <p>Findings:</p> <p>During a review of facilities Performance improvement Project indicated the facility did not have a written system in place to identify adverse events that included monitoring investigating, analyzing root cause, implement and evaluate its Quality Assurance and Performance Improvement Program, such in the case of Resident 77 ' s death.</p> <p>During a review if the facility's QAPI program indicated the facility did not perform an investigation to what lead to Resident 77 ' s death on [DATE]. Resident 77 had a significant change of condition to prevent recurrence of the deficient practice that impact quality of care, quality of life, and resident safety.</p> <p>During a review of Resident 77's Admission Record (AR), the AR indicated the facility admitted Resident 77 on [DATE] and readmitted on [DATE] with diagnoses that included COPD with exacerbation, pneumonia, hypertensive heart disease without heart failure, type 2 diabetes mellitus without complications.</p> <p>For Resident 77 the facility failed to:</p> <ol style="list-style-type: none"> 1. Monitor the resident for respiratory distress and change in respiratory condition, in accordance with the resident ' s care plan for COPD and physician orders, when Resident 77 experienced shortness of breath (SOB), labored breathing, and an oxygen saturation of 72% while on oxygen via nasal cannula (NC) at 2 LPM. <p>(continued on next page)</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Follow physician orders to titrate the resident ' s oxygen at ,d+[DATE] liters to maintain oxygen levels of 92% and above, when Resident 77 ' s oxygen saturation was 72% on [DATE] at 12:10 AM, while on 2 LPM of oxygen via NC.</p> <p>3. Ensure LVN 77 monitor and document Resident 77 ' s respiratory distress, treatments rendered, and report to the physician, in accordance with the physician orders.</p> <p>4. Notify physician and 911 emergency services immediately, when Resident 77 complained of not being able to breath and exhibited signs and symptoms of respiratory distress as manifested by labored breathing and oxygen saturation of 72% on [DATE] at 12:10 AM.</p> <p>During a concurrent interview and record review on [DATE] at 12:07 PM of the facilities QAPI/QAA (/Quality Assurance and Performance Improvement- data driven and proactive approach to quality improvement/Quality Assessment and Assurance - A Committee is responsible for identifying and responding to quality deficiencies that are identified in the facility) the Administrator (ADM) and Director of Nursing (DON) revealed several concerns. The DON stated that the facility had not identified or incorporated any adverse events into the QAPI program and confirmed that the cause of death of Resident 77 had not been investigated to determine if quality deficiencies existed or if corrective measures were necessary. Additionally, the DON confirmed that the current QAPI program focuses solely on fall prevention. The ADM stated that efforts are underway to hire a Registered Nurse (RN) for the night shift to address staffing gaps.</p> <p>During a review of the facility ' s policy and procedure titled QAPI Program with a revision date of [DATE] indicated The QAPI program overseen by the QAPI committee is designated Program designed to monitor and evaluate the quality of resident care, pursue methods to improve care quality, and resolve identified problems.</p>		