| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056362 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mesa Verde Post Acute Care Center | 661 Center Street<br>Costa Mesa, CA 92627 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of four residents observed for medication administration (Resident 23) and one of 18 final sampled residents (Resident 18) were assessed to safely self-administer the medications prior to performing the self-administering medications. This had the potential for the residents to incorrectly administer the medications.<br><br>Findings:<br><br>Review of the facility's P&P Medication-Self Administration revised 1/1/12, showed the following:<br><br>-The licensed nurse will complete the Assessment for Self-Administration of Medications.<br><br>-The physician must provide an order permitting the resident to self-administer medication.<br><br>-Self-administration of medications will be documented in the resident's care plan and the MAR.<br><br>1. On 6/4/24 at 0838 hours, a medication administration observation with LVN 1 was conducted for Resident 23. During the observation, LVN 1 drew up 40 units of insulin glargine KwikPen and handed the injector pen to Resident 23. Resident 23 was observed injecting the insulin into his abdomen.<br><br>Medical record review for Resident 23 was initiated on 6/4/24. Resident 23 was readmitted to the facility on [DATE].<br><br>Review of Resident 23's H&P examination dated 12/23/23, showed the resident had the capacity to understand and make decisions.<br><br>Review of Resident 23's Order Summary Report dated 6/4/24, showed the following orders:<br><br>-An order dated 3/1/24, for Humalog (insulin, a medication that lowers blood sugar) KwikPen, inject subcutaneously (beneath the skin) per sliding scale before meals and at bedtime.<br><br>-An order dated 10/6/23, for insulin glargine, inject 40 units subcutaneously two times a day.<br><br>The record failed to show a physician's order to allow Resident 23 to self-administer medications.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 23's N Adv-Self-Administration of Medication dated 8/1/23, showed the resident was not capable of self-administering subcutaneous injections. The assessment also showed all the resident's medications were going to be administered by the nurse.<br><br>Review of Resident 23's plan of care failed to show a care plan was developed to address the resident's self-administration of medications.<br><br>On 6/4/24 at 1142 hours, an interview and concurrent medical record review were conducted with LVN 1. LVN 1 stated Resident 23 usually self-administered his insulin injection, and stated it was in the resident's care plan. LVN 1 reviewed Resident 23's care plan, and stated he was unable to find where it showed the resident was able to self-administer his insulin injections. LVN 1 reviewed Resident 23's N Adv-Self-Administration of Medication, and stated the assessment dated [DATE] was the most recent assessment for the resident. The LVN 1 verified the assessment showed the resident was not capable of self-administering subcutaneous injections and all the resident's medications were going to be administered by the nurse.<br><br>On 6/4/24 at 1149 hours, an interview was conducted with Resident 23 at his bedside. Resident 23 stated he had been self-administering his insulin since he was admitted to the facility.<br><br>32179<br><br>2. Medical record review of Resident 18 was initiated on 6/3/24. Resident 18 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 18's H&P examination dated 4/3/24, showed Resident 18 had fluctuating capacity to understand and make decisions.<br><br>Review of Resident 18's N Adv-Self-Administration of Medication dated 4/3/24, showed all medications to be administered by the skilled nurse and Resident 18 was not approved for self-administration of medications.<br><br>Review of Resident 18's Order Summary Report dated 6/2/24, showed a physician's order to administer amoxicillin-pot clavulanate (antibiotic) suspension reconstituted 250-62.5 mg /5 ml give 10 ml by mouth in the evening every Tuesday, Thursday, and Saturday for aspiration pneumonia for two days and unsupervised self-administration starting on 6/4/24.<br><br>Review of Resident 18's MAR for June 2024 showed a physician's order dated 6/2/24, for the amoxicillin-pot clavulanate medication to be self-administered by Resident 18 unsupervised starting on 6/4/24 for two days.<br><br>Review of Resident 18's plan of care dated 6/2/24, showed a care plan problem addressing Resident 18's use of the amoxicillin medication for two days. The interventions included to give the medication as ordered.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/4/24 at 1045 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 was asked if Resident 18 was assessed for self-administration of the medications. RN 1 stated Resident 18 was assessed and could not self-administer the medications. RN 1 was unable to provide the documentation to show the physician's order for the medication was clarified with the physician. RN 1 acknowledge the physician's order had been transcribed into Resident 18's MAR and had the potential for the resident to self-administer the antibiotic. RN 1 verified the above findings. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179<br><br>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to promote dignity and respect for two of 18 final sampled residents (Residents 18 and 23) and four nonsampled residents (Residents 4, 22, 60, and 62).<br><br>* The call light was not within reach for Residents 18, 22, and 62.<br><br>* The facility failed to ensure the resident's call lights were answered in a timely manner for Residents 4, 23, and 60.<br><br>These failures posed the risk to negatively affect the residents' physical and emotional well-being.<br><br>Findings:<br><br>Review of the facility's P&P titled Communication-Call System dated 1/1/12, showed the call cords will be placed with the resident's reach in the resident's room, nursing staff will answer call bells promptly in a courteous manner.<br><br>1. Medical record review for Resident 4 was initiated on 6/4/24. Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE].<br><br>Review of Resident 4's Quarterly MDS dated [DATE], under the toileting hygiene and toilet transfer section, showed Resident 4 was dependent and the helper did all the effort.<br><br>On 6/4/24 at 1010 hours, a concurrent observation and interview was conducted with Resident 4. Resident 4 was observed sitting up in wheelchair during the resident council meeting. Resident 4 expressed the concern regarding the staff hiding the call light at night shift (2300 hours to 0700 hours) and putting the call light out of reach. Resident 4 stated if the staff responded and the resident has fallen asleep, the staff turns off the call light and don't wake the resident up. Resident 4 stated she had wait longer than one hour for staff to answer the call light. Resdent 4 further stated this had been brought in the resident council meeting and it was still an ongoing issues.<br><br>On 6/6/24 at 0830 hours, an interview was conducted with CNA 6. CNA 6 stated Resident 4 had incontinence of bowel and bladder. CNA 6 stated Resident 4 sometimes used the call light for assistance on diaper change or to be cleaned.<br><br>2. Medical record review for Resident 23 was initiated on 6/4/24. Resident 23 was admitted to the facility on [DATE] and readmitted on [DATE].<br><br>Review of Resident 23's H&P examination dated 12/23/23, showed Resident 23 had capacity to understand and make decisions.<br><br>Review of Resident 23's Quarterly MDS dated [DATE], under the toileting hygiene and toilet transfer section, showed Resident 23 required partial or moderate assistance.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/4/24 at 1020 hours, a concurrent observation and an interview was conducted with Resident 23. Resident 23 was observed sitting up in wheelchair during the resident council meeting. Resident 23 stated he had to wait for the staff answering the call lights during the night shift for 30 minutes or longer for assistance to the bathroom or empty the urinal and the CNA told them they have not enough staffing. Resident 23 stated sometimes the staff turn the call lights off without attending to their needs. Resident 23 further stated this has been discussed in the resident council meeting and had been an ongoing issues.<br><br>On 6/6/24 at 0425 hours, an interview was conducted with CNA 5. CNA 5 stated Resident 23 often used the call light at the night shift for emptying the urinal, asked for ice or water, and assistance to the bathroom or repositioning.<br><br>3. Medical record review for Resident 18 was initiated on 6/3/24. Resident 18 was admitted to the facility on [DATE] and readmitted on [DATE].<br><br>Review of Resident 18's H&P examination dated 4/3/24, showed Resident 18 had fluctuating capacity to understand and make decisions.<br><br>Review of Resident 18's Plan of Care dated 6/4/24, showed a care plan problem to address Resident 18 had activity of daily living self-care performance deficit related to activity intolerance, impaired balance, limited mobility and quadriplegia (paralysis of four limbs). The interventions included for staff to encourage Resident 18 to use the call light to call for assistance.<br><br>On 6/5/24 at 0405 hours, Resident 18 was observed awake and laying in bed. Resident 18's call light was on the floor. Resident 18 was asked if she could reach her call light, Resident 18 stated no.<br><br>On 6/5/24 at 0445 hours, LVN 7 was summoned to Resident 18's room. Resident 18's call light was observed on the floor. LVN 7 acknowledged Resident 18 could not reach her call light. LVN 7 verified the findings.<br><br>4. Medical record review for Resident 22 was initiated on 6/3/24. Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE].<br><br>Review of Resident 22's Plan of Care dated 12/19/23, showed a care plan problem to address Resident 22 had activity of daily living self-care performance deficit related to activity intolerance, dementia, communication deficit, cognition impaired, impaired hearing or vision, diagnosis of diabetes melitus (elevated blood sugar), high blood pressure, anemia, muscle weakness, morbid obesity, dementia, history of deep vein thrombosis (blood clot), hypothyroidism (low thyroid level). The intervention included for staff to encourage the Resident 22 to use the call ligh for assistance.<br><br>On 6/5/24 at 0400 hours, Resident 22 was observed sleeping in bed and the call light was observed on the floor.<br><br>On 6/5/24 at 0500 hours, LVN 6 was summoned to Resident 22's room. Resident 22's call light was observed on the floor and LVN 6 verified the finding.<br><br>47476<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5. On 6/5/24 at 0408 hours, Resident 62's lights were off and Resident 62 appeared to be asleep in bed. Resident 62's call light was observed to be on the floor.<br><br>On 6/5/24 at 0446 hours, a concurrent observation and interview was conducted with CNA 3 in Resident 62's room. Resident 62 was observed to be lying in bed asleep and her call light was observed on the floor. CNA 3 stated Resident 62 would use the call light during the shift to ask for help or medicine. CNA 3 verified the call light was on the floor and not within reach of Resident 62. CNA 3 further stated the call light should be within her reach.<br><br>Medical record review for Resident 62 was initiated on 6/3/24. Resident 62 was admitted to the facility on [DATE].<br><br>Review of Resident 62's H&P examination dated 1/10/24, showed Resident 62 had the capacity to understand and make decisions.<br><br>Review of Resident 62's MDS dated [DATE], showed Resident 62 was dependent for toileting hygiene.<br><br>6. On 6/3/24 at 1031 hours, an interview was conducted with Family Member A. Family Member A stated the staff took a long time, a couple hours to answer the call lights during the night shift. Family Member A stated she knew how long it took the staff to answer the call light because Resident 60 would call her, and she would be on the phone with her until the staff answered the call light. Family Member A further stated Resident 60 was incontinent and Resident 60 felt agitated about waiting for hours for the staff to help her.<br><br>Medical record review for Resident 60 was initiated on 6/3/24. Resident 60 was readmitted to the facility on [DATE].<br><br>On 6/6/24 at 0925 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 60 could make her needs known and use the call light to ask for assistance. CNA 4 stated Resident 60 was totally dependent for dressing, changing, and hygiene. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plan was formulated for two of 18 final sampled residents (Residents 17 and 423).<br><br>* The facility failed to develop a care plan problem to address the use of CVAD (Central Venous Access Device - a type of intravenous catheter) for Resident 423.<br><br>* The facility failed to develop a care plan problem to address Resident 17's need for a cervical collar and TLSO brace (Thoracic-Lumbar-Sacral Orthosis, used to limit motion and stabilize the back).<br><br>These failures posed the risk of not providing the appropriate, consistent, and individualized care of the residents.<br><br>Findings:<br><br>Review of the facility's P&P titled Comprehensive Person-Centered Care Planning dated 9/7/23, showed the plan of care should be based on the assessed needs of the residents. The comprehensive care plans should be reviewed and revised based on the onset of new problems, change of condition, and other time as appropriate and necessary.<br><br>1. On 6/3/24 at 1056 hours, an observation and concurrent interview was conducted with Resident 423. Resident 423 was observed in bed with a single line of CVAD on the right upper arm. Resident 423 stated the IV was used for the antibiotic medication for the infection on his lower leg.<br><br>Medical record review for Resident 423 was initiated on 6/3/24. Resident 423 was admitted to the facility on [DATE].<br><br>Review of Resident 423's Order Summary Report dated 6/4/24, showed a physician's order dated 5/29/24, to insert midline for IV treatment with antibiotic.<br><br>Review of Resident 423's plan of care failed to show documented evidence a care plan problem was developed to address the use of CVAD line.<br><br>On 6/4/24 at 1010 hours, an interview and concurrent medical record review for Resident 423 was conducted with RN 1. RN 1 verified Resident 423's use of CVAD was for IV antibiotic. RN 1 verified there was no plan of care developed to address the use of CVAD.<br><br>On 6/6/24 at 1046 hours, an interview and concurrent medical record review for Resident 423 was conducted with the DON. The DON was informed and verified the above findings.<br><br>47476<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. During an initial tour of the facility on 6/3/24 at 0845 hours, Resident 17 was observed lying in bed. A cervical collar (c-collar, used to support the spinal cord and head) was observed on the top of Resident 17's bedside drawer. Resident 17 stated he was hit by car a couple weeks ago while he was in his wheelchair.<br><br>Medical record review for Resident 17 was initiated on 6/3/24. Resident 17 was admitted to the facility on [DATE].<br><br>Review of Resident 17's Psych Progress Note dated 4/24/24, showed Resident 17 had the capacity to understand and make his own medical decisions.<br><br>Review of Resident 17's Order Summary Report dated 6/5/24, showed a physician's order dated 4/12/24, for the application of the c-collar on at all times, TLSO for out of bed activities or HOB greater than 30 degrees.<br><br>Review of Resident 17's plan of care failed to show the application of the c-collar, TLSO when out of bed, or noncompliance were addressed.<br><br>On 6/4/24 at 1534 hours, an interview and concurrent medical record review was conducted with the DOR. The DOR verified Resident 17 did not wear the c-collar as ordered by the physician. The DOR stated Resident 17 received a c-collar and a back brace but was non-compliant with wearing both the c-collar and back brace. The DOR verified Resident 17's care plan did not address Resident 17's need and noncompliance with the application of the c-collar. The DOR stated the nursing staff should have documented Resident 17's refusal to wear the c-collar.<br><br>On 6/4/24 at 1600 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 verified she had never seen Resident 17 wearing a c-collar or back brace and/or attempted to apply one for Resident 17 per the physician's orders. LVN 5 stated she was not aware of why Resident 17 was not using the c-collar. LVN 5 verified there was no care plan to address Resident 17's application and refusal of the c-collar or TLSO brace when out of bed.<br><br>On 6/5/24 at 0530 hours, an interview and concurrent medical record review was conducted with the DON and MDS coordinator. The DON and MDS Coordinator were informed and acknowledged the above findings.<br><br>Cross reference to F684. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476<br><br>Based on observation, interview, medical record review, and facility document review, the facility failed to provide the necessary treatment and services for one of three residents who were reviewed for positioning and mobility (Resident 17). The facility failed to apply a cervical collar (c-collar) to Resident 17 as ordered by the physician. This failure had the potential to negatively affect the Resident 17's health and well-being.<br><br>Findings:<br><br>Review of the facility document titled Your Path to Recovery After Cervical Spine Surgery revised 11/2015 showed a cervical collar is worn at the discretion of the surgeon. Under the section titled Spine Precautions, showed a cervical collar is used to provide support and limit movement of the neck. Your doctor may or may not order a cervical collar. Typically, the collar should be worn at all times. Cervical collar is worn at the discretion of the surgeon.<br><br>During an initial tour of the facility on 6/3/24 at 0845 hours, Resident 17 was observed lying in bed. A c-collar was observed on the top of Resident 17's bedside drawer. Resident 17 stated he was hit by car a couple weeks ago while he was in his wheelchair.<br><br>Medical record review for Resident 17 was initiated on 6/3/24. Resident 17 was admitted to the facility on [DATE].<br><br>Review of Resident 17's Psych Progress Note dated 4/24/24, showed Resident 17 had the capacity to understand and make his own medical decisions.<br><br>Review of Resident 17's Order Summary Report dated 6/5/24, showed a physician's order dated 4/12/24, for the application of the c-collar on at all times, TLSO for out of bed activities or HOB greater than 30 degrees.<br><br>Review of Resident 17's plan of care failed to show the application of the c-collar, TLSO when out of bed, or noncompliance were addressed.<br><br>On 6/4/24 at 1138 hours, Resident 17 was observed lying in bed without a c-collar on.<br><br>On 6/4/24 at 1534 hours, an interview and concurrent medical record review was conducted with the DOR. The DOR verified Resident 17 did not wore the c-collar as ordered by the physician. The DOR stated Resident 17 received a c-collar and a back brace but was non-compliant with wearing both. The DOR stated Resident 17 should have had a follow up appointment with the orthopedic specialist and the c-collar order could only be addressed by an orthopedic specialist.<br><br>On 6/4/24 at 1550 hours, an interview was conducted with RNA 1. RNA 1 verified Resident 17 was currently receiving RNA services. RNA 1 stated Resident 17 did not use a brace and stated she was never instructed to apply a c-collar or back brace on Resident 17.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/4/24 at 1600 hours, an interview and concurrent record review was conducted with LVN 5. LVN 5 verified she had never seen Resident 17 wearing a c-collar or back brace and/or attempted to apply one for Resident 17 per the physician's orders. LVN 5 stated she was not aware of why Resident 17 was not using the c-collar.<br><br>On 6/5/24 at 0528 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 stated Resident 4 did not use the c-collar or back brace and did not know if Resident 17 needed them. LVN 4 stated she was not sure if Resident 17 had refused to wear the c-collar. LVN 4 then went inside Resident 17's room and asked Resident 17 about the c-collar. Resident 17 was observed to be without a c-collar on and stated it was very uncomfortable to wear.<br><br>On 6/5/24 at 0530 hours, an interview and concurrent medical record review was conducted with the DON and MDS coordinator. The DON and MDS Coordinator were informed and acknowledged the above findings. The DON stated Resident 17 had been refusing to wear the c-collar and the physician was aware, however, the DON was unable to provide documented evidence the physician or orthopedic specialist was notified about Resident 17's refusal. The MDS Coordinator verified Resident 17 had not been seen by an orthopedic specialist during his admission to the facility.<br><br>Cross reference to F656, example #2. |

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| Mesa Verde Post Acute Care Center | 661 Center Street<br>Costa Mesa, CA 92627 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide a safe environment free from potentially serious accident hazards for one of one residents who were reviewed for smoking (Resident 24). The facility failed to ensure the smoking materials for Resident 24 were securely stored. This posed the risk of fire and serious injuries to the residents who resided in the facility.<br><br>Findings:<br><br>Review of the facility's P&P titled Smoking Residents revised 7/27/23, showed the IDT will develop an individualized plan of care for safe storage, use of smoking materials, assistance, and/or required supervision, for residents who smoke.<br><br>On 6/5/24 at 0415 hours, an observation and concurrent interview was conducted with Resident 24 in his room. A box of cigarettes was observed to be stored inside a bag on the ground. When asked about the cigarettes, Resident 24 stated the facility did not let him store the cigarettes in his room but kept them because the facility would forget about them.<br><br>Medical record review for Resident 24 was initiated on 6/3/24. Resident 24 was readmitted to the facility on [DATE].<br><br>Review of Resident 24's H&P examination dated 7/1/23, showed Resident 24 had the capacity to understand and make decisions.<br><br>Review of Resident 24's plan of care showed a care plan problem dated 11/24/2, to address Resident 24's tobacco use. The interventions included for the cigarettes and lighter to be stored in a designated box.<br><br>On 6/5/24 at 0425 hours, an observation and concurrent interview was conducted with LVN 4 for Resident 24 in Resident 24's room. LVN 4 acknowledged the above findings. LVN 4 stated the facility allowed Resident 24 to have his own cigarettes and lighter. LVN 4 stated Resident 24 kept his cigarettes in his room and verified the facility did not take his smoking materials for safe storage.<br><br>On 6/5/24 at 0448 hours, an observation and concurrent interview was conducted with RN 2. RN 2 verified the above findings. RN 2 stated the cigarettes should not be kept in his room and should be kept in a locked box with his name and room number. RN 2 proceeded to take Resident 24's cigarettes, then placed them into a locked container located in the nurse's station. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476<br><br>Based on observation, interview, and medical record review, the facility failed to provide the appropriate care and services to prevent UTI (urinary tract infection, a condition associated with invasion by disease causing microorganisms of some part of the urinary tract) for one of one resident (Resident 24) reviewed for urinary catheter or UTI. Resident 24 had a suprapubic catheter (a tube used to drain urine from the bladder through an incision in the abdomen) and a history of recurrent UTIs. The facility failed to ensure proper positioning of Resident 24's urinary drainage bag to prevent urine from flowing back into the bladder. This posed the risk for Resident 24 to develop a catheter-associated urinary tract infection (CAUTI).<br><br>Findings:<br><br>Review of the Centers for Disease Control and Prevention's (CDC) topic titled Catheter-Associated Urinary Tract Infections (CAUTI) Prevention Guideline dated 4/2024, showed urinary tract infections are the most common type of healthcare associated infection. CAUTI has been associated with increased morbidity, mortality, hospital cost, and length of stay. The section titled Proper Techniques for Urinary Catheter Maintenance, showed to keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor.<br><br>During an initial tour of the facility on 6/3/24 at 1246 hours, Resident 24 was observed laying in bed with an urinary catheter tubing attached to a urinary drainage bag. The urinary drainage bag was observed laying on the floor.<br><br>Medical record review for Resident 24 was initiated on 6/3/24. Resident 24 was readmitted to the facility on [DATE].<br><br>Review of Resident 24's H&P examination dated 7/1/23, showed Resident 24 had the capacity to understand and make decisions.<br><br>Review of Resident 24's Change in Condition Evaluation dated 5/29/24, showed Resident 24 had a UTI started on 5/29/24 and was started on antibiotics.<br><br>On 6/5/24 at 0415 hours, an observation and concurrent interview was conducted with Resident 24. Resident 24's urinary drainage bag was observed laying on the floor. Resident 24 stated he currently had a UTI. Resident 24 stated he would put the urinary drainage bag on the floor himself and sometimes put it in a trash bag. Resident 24 stated the facility did not educated him about the urinary drainage bag being placed on the floor.<br><br>On 6/5/24 at 0425 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 verified the above findings. LVN 4 stated the urinary drainage bag should not be on the floor because of bladder problems.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/5/24 at 0545 hours, an interview was conducted with the MDS Coordinator. The MDS Coordinator was informed and acknowledged the above findings. The MDS Coordinator stated Resident 24 had a suprapubic catheter and history of recurrent UTIs. The MDS Coordinator stated the urinary drainage bag should be kept in a dignity bag and not placed on the floor for infection control. |

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| F 0693<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50126<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary GT care and services for one of one resident reviewed for GT care (Resident 45).<br><br>*Resident 45's GT feeding bottle label did not indicate the start time of the feeding and the initials of the nurse who hung the tube feeding.<br><br>This failure had the potential for the residents to develop complications related to tube feedings and/or risk for infections.<br><br>Findings:<br><br>Review of the facility's P&P titled Enteral Feedings 9/7/23, showed to label the bag and tubing with the date and time hung. Hang time is for no more than 24 hours.<br><br>On 6/3/24 at 1235 hours and 6/4/24 at 1145 hours, an observation was conducted with Resident 45. Resident 45's tube feeding bottle label was observed with the resident's name, room number, and date. However, the tube feeding label did not include the start time and the nurse's initials who hung the tube feeding.<br><br>Medical record review for Resident 45 was initiated on 6/5/24. Resident 45 was admitted to the facility on [DATE].<br><br>Review of Resident 45's H&P examination dated 4/15/24, showed Resident 45 had no capacity to understand and make decisions.<br><br>Review of Resident 45's Order Summary Report dated 6/6/24, showed a physician's order dated 5/22/24, to administer Jevity 1.2 (a type of feeding formula) at 65 ml/hr via pump for 20 hours to provide 1200/ml or 1560 kcals.<br><br>On 6/3/24 at 1430 hours, an interview was conducted with the IP. When asked about the process for labeling the tube feeding when the bottle was changed, the IP stated the tube feeding was changed during the night shift. The label needed to have the resident's name, date hung, start time, room number, and the nurse's initials. The IP verified the tube feeding label did not include the start time and the nurse's initials.<br><br>On 6/5/24 at 0739 hours, an interview was conducted with LVN 1. When asked about the process for labeling the tube feeding when the bottle was changed, LVN 1 stated the tube feeding was changed during the night shift. LVN 1 stated the label needed to have the resident's name, date hung, start time, room number, and the nurse's initials.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | On 6/5/24 at 0951 hours, an interview was conducted with the DON and Administrator. The DON stated the tube feeding label should include the resident's name, date, time started, room number, and initials of the nurse. The DON further stated the facility's enteral feeding policy should have included the initials of the nurse who hung the tube feeding. The Administrator was informed and acknowledged the above findings. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure four of four residents reviewed for respiratory care (Residents 14, 50, 44, and 623) were provided with the appropriate respiratory care when:<br><br>* The facility failed to ensure the nasal cannula was dated and labeled, and the nebulizer mask was stored properly for Residents 14 and 50.<br><br>* The facility failed to ensure the CPAP mask was stored properly for Resident 623.<br><br>* The facility failed to ensure the nasal cannula was stored properly for Resident 44.<br><br>These failures had the potential to affect the respiratory health and well-being of the residents in the facility.<br><br>Findings:<br><br>Review of the facility's P&P titled Oxygen Therapy dated 11/2017 showed oxygen is administered under safe and sanitary conditions to meet resident needs. Administer oxygen per physician's order and tubing, mask, and cannulas should be changed every seven days and labeled with the date of change.<br><br>1. During the initial facility tour on 6/3/24 at 1051 hours, Resident 14 was observed in bed and with a nebulizer machine on top of the bedside drawer. A nebulizer mask was stored inside the top drawer and not in a respiratory bag.<br><br>Medical record review for Resident 14 was initiated on 6/4/24. Resident 14 was admitted to the facility on [DATE].<br><br>Review of Resident 14's H&P examination dated 5/2/24, showed Resident 14 had the capacity to understand and make decisions.<br><br>Review of Resident 14's Order Summary Report dated 6/4/24, showed a physician's order dated 5/7/24, to administer albuterol sulfate nebulization solution (2.5 mg per 3 ml) 0.083% 3 ml inhale orally two times a day and every six hours as needed for shortness of breath or asthma (lung disease causing the airways to narrow, swell and produce extra mucus).<br><br>2. During the facility initial tour on 6/3/24 at 1054 hours, Resident 50 was observed lying in bed wearing a nasal cannula attached to an oxygen machine with a setting of three liters per minute, the oxygen tubing was unlabeled. A nebulizer mask was stored on top of the bedside drawer unlabeled and not in a respiratory bag.<br><br>Medical record review for Resident 50 was initiated on 6/4/24. Resident 50 was admitted to the facility on [DATE].<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 50's H&P examination dated 5/16/24, showed Resident 50 had no capacity to understand and make decisions, and had a diagnosis of acute pulmonary edema (excessive fluid accumulation in the lungs) and shortness of breath.<br><br>Review of Resident 50's Order Summary Report dated 6/4/24, showed the following physician's orders:<br><br>-dated 5/15/24, to administer oxygen via nasal cannula at four liters per minute to keep oxygen saturation above 93 % for shortness of breath.<br><br>-dated 5/15/24, to administer ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg per ml inhale orally three times a day and every four hours as needed for shortness of breath.<br><br>On 6/3/24 at 1026 hours, an observation and concurrent interview for Resident 14 and 50 was conducted with LVN 7. LVN 7 verified the above findings. LVN 7 stated the nebulizer mask should have been placed in a clear plastic bag.<br><br>On 6/3/24 at 1035 hours, an interview for Resident 14 and 50 was conducted with RN 1. RN 1 stated the nebulizer mask and oxygen tubing should have been placed in a clear plastic bag after each use and with a label. RN 1 verified the above findings.<br><br>On 6/6/24 at 1020 hours, an interview for Resident 14 and 50 was conducted with the DON. The DON was informed and verified the above findings.<br><br>47476<br><br>3. Review of the facility's P&P titled BiPAP and CPAP revised 10/2019 showed equipment should be kept in a labeled plastic bag with resident name or container provided by the machine manufacturer.<br><br>During an initial tour of the facility on 6/3/24 at 0941 hours, Resident 623's CPAP mask was observed laying on top of Resident 623's bedside drawer. Resident 623 was not observed to be in his room.<br><br>On 6/3/24 at 1143 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified the above findings and stated the CPAP mask should be stored in a plastic bag when not in use.<br><br>Medical record review for Resident 623 was initiated on 6/3/24. Resident 623 was admitted to the facility on [DATE].<br><br>On 6/5/24 at 0541 hours, an interview was conducted with the MDS Coordinator. The MDS Coordinator was informed and acknowledged the above findings. The MDS Coordinator stated the CPAP mask should be stored in a respiratory bag.<br><br>4. During an initial tour of the facility on 6/3/24 at 0944 hours, Resident 44's nasal cannula tubing was observed laying on top of Resident 44's wheelchair, not being used.<br><br>On 6/3/24 at 1143 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified the above findings and stated the nasal cannula should be stored in a plastic container when not in use.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Medical record review for Resident 44 was initiated on 6/3/24. Resident 44 was readmitted to the facility on [DATE].<br><br>On 6/5/24 at 0541 hours, an interview was conducted with the MDS Coordinator. The MDS Coordinator was informed and acknowledged the above findings. The MDS Coordinator stated the nasal cannula tubing should be stored in a respiratory bag. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the dialysis care was provided for one of one final sampled resident reviewed for dialysis services (Resident 29) as evidenced by:<br><br>* The facility failed to ensure Resident 29's dialysis access site was assessed and monitored appropriately and consistently. The licensed staff failed to assess Resident 29's dialysis access site after returning from the dialysis clinic accurately. In addition, the licensed staff failed to document an assessment of Resident 29's dialysis access upon return from the dialysis clinic.<br><br>These failures had the potential for Resident 29 not being provided with appropriate care and treatment and the possibility of medical complications related to the resident's dialysis access site.<br><br>Findings:<br><br>Review of the facility's P&P titled Dialysis Care revised 10/1/18, showed for the licensed staff caring for the residents with dialysis AV (Arteriovenous) shunt should inspect for functionality and sign and symptoms of complications. Documentation included pre/post dialysis assessment, dialysis flow sheet-return assessment, and dialysis medical intake sheet.<br><br>On 6/3/24 at 1058 hours, an interview was conducted with Resident 29. Resident 29 stated she received dialysis on Tuesdays, Thursdays, and Saturdays.<br><br>Medical record review for Resident 29 was initiated on 6/4/24. Resident 29 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 29's H&P examination dated 5/29/24, showed Resident 29 had the capacity to understand and make decisions.<br><br>Review of Resident 29's Order Summary Report the following physician's orders dated 5/29/24:<br><br>- dialysis every Tuesday and Saturday for 4 hours at dialysis center.<br><br>- to monitor the AV shunt on left upper arm for bruit and thrill every shift.<br><br>- to observe the AV shunt site and dressing on left upper arm and change as directed by the physician every shift.<br><br>Review of Resident 29's Pre-Dialysis Evaluation dated 6/1/24, showed Resident 29 refused to complete the four hours treatment and signed against medical advice. However, further review of the medical records failed to show documented evidence on the information as to what was the reason of Resident 29's refusal to finish the therapy, for how many hours did Resident 29's treatment was completed, and if the physician was notified.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/6/24 at 0902 hours, an observation and concurrent interview for Resident 29 was conducted with LVN 3. Resident 29 was observed in bed with a dry dressing on the left upper arm dialysis access. Resident 29 stated she received dialysis yesterday and came back to the facility around 1530 hours. LVN 3 verified a dry dressing on the left upper arm of Resident 29. LVN 3 stated the licensed staff who received the resident from dialysis should have assessed the resident, including the access site. LVN 3 stated the dressing should be remove four hours after dialysis, to have an accurate assessment of the dialysis access site.<br><br>Further review of Resident 29's medical record failed to show a post dialysis assessment on 6/5/24.<br><br>On 6/6/24 at 0923 hours, an interview and concurrent medical record review for Resident 29 was conducted with RN 1. RN 1 was asked for the post dialysis assessment of Resident 29 on 6/5/24. RN 1 was unable to find documented evidence an assessment was done when Resident 29 was received from the dialysis center. RN 1 was asked about the assessment of the dialysis access site of the resident. RN 1 stated the dialysis access site dressing should have been removed for an accurate assessment.<br><br>On 6/6/24 at 1049 hours, an interview and concurrent medical record review for Resident 29 was conducted with the DON. The DON was informed and verified the above findings. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683<br><br>Based on observation, interview, medical record review, facility document review, and facility P&P, the facility failed to provide the pharmaceutical services to meet the residents' needs for two of two residents (Residents 17 and 23) reviewed for controlled medication administration.<br><br>*The facility failed to ensure Resident 17 and 23's controlled pain medications were accurately reconciled. The controlled pain medications removed as shown on the Individual Narcotic Record were not recorded as administered on the electronic MAR. This failure had the potential for drug diversion.<br><br>Findings:<br><br>Review of the facility's P&P Preparation and General Guidelines - IIA5: Controlled Medications dated August 2014 showed when a controlled medication is administered, the nurse will immediately document the following in the accountability record and the MAR:<br><br>-the date and time of administration, the amount administered, and the initials of the nurse administering the medication in the MAR.<br><br>1. Medical record review for Resident 17 was initiated on 6/4/24. Resident 17 was admitted to the facility on [DATE].<br><br>Review of Resident 17's Individual Narcotic Record for oxycodone hcl (controlled pain medication) 10 mg tablets, initiated 5/18/24, showed one tablet was removed from the supply on 5/23/24 at 1400 hours.<br><br>Review of Resident 17's MAR for May 2024, failed to show oxycodone hcl 10 mg was documented as administered on 5/23/24.<br><br>On 6/4/24 at 0824 hours, an interview and concurrent medical record review were conducted with LVN 1. LVN 1 verified Resident 17's medical record and verified the oxycodone hcl 10 mg tablet was removed from the supply on 5/23/24 at 1400 hours, but it was not documented on the resident's MAR.<br><br>2. Medical record review for Resident 23 was initiated on 6/4/24. Resident 23 was readmitted to the facility on [DATE].<br><br>Review of Resident 23's Individual Narcotic Record for Norco (controlled pain medication) 5-325 mg tablets, initiated 5/16/24, showed one tablet was removed from the supply on 6/3/24 at 2140 hours.<br><br>Review of Resident 23's MAR for June 2024, failed to show Norco 5-325 mg was documented as administered on 6/3/24.<br><br>(continued on next page) |

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|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/4/24 at 0824 hours, an interview and concurrent medical record review were conducted with LVN 1. LVN 1 Resident 23's medical record and verified the Norco 5-325 mg tablet was removed from the supply on 6/3/24 at 2140 hours, but it was not documented on the resident's MAR. LVN 1 stated the above controlled medications should have been documented on the MAR. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179<br><br>Based on interview, medical record review, and facility document review, the facility failed to ensure the Pharmacy Consultant's recommendations were acted upon for one of five residents reviewed for unnecessary medications(Residents 61). This failure had the potential to put Resident 61 at risk for adverse consequences related to the medication.<br><br>Findings:<br><br>1. Medical review of Resident 61 was initiated on 6/3/24. Resident 61 was admitted to the facility on [DATE].<br><br>Review of Resident 61's Order Summary Report dated 5/28/24, showed a physician's order dated 1/12/24, to administer buspirone HCL (antianxiety medication) 5 mg one tablet by mouth two times a day for anxiety manifested by restlessness.<br><br>Review of Resident 61's Consultant Pharmacist's Medication Regimen Review between 5/1/24 and 5/13/24, showed agitation or restlessness too subjective and should not be used as a diagnosis nor as a behavior. Please updated the order with a specific and quantifiable behavior.<br><br>Further review of Resident 61's medical record did not show documented evidence Resident 61's physician was notified or if the Pharmacy Consultant's recommendation for the buspirone was acted upon.<br><br>On 6/5/24 at 1115 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 was asked regarding the pharmacy recommendation for Resident 61's buspirone medication. RN 1 stated she had followed up with the physician and the manifested behavior was changed to resisting care. RN 1 was asked to provide the documentation to show who the doctor she spoke with and when was she made the call. RN 1 was unable to provide the documentation. RN verified the above findings. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683<br><br>Based on observation, interview, and facility P&P review, the facility failed to ensure the expired and potentially deteriorated medications were removed from the supply for two of three medication carts (Medication Carts A and B). This had the potential for expired or deteriorated medications to be administered to the residents.<br><br>Findings:<br><br>Review of the facility's P&P Medication Storage In The Facility effective [DATE] showed outdated or deteriorated medications will be immediately removed from stock and disposed of.<br><br>1. On [DATE] at 1219 hours, an inspection of Medication Cart B was conducted with RN 1. Two 10 ml vials of injectable sterile water with the expiration dates of [DATE] and [DATE], were observed in the cart. RN 1 verified the two vials were expired and stated the expired vials should have been removed from the cart.<br><br>2. On [DATE] at 1406 hours, an inspection of Medication Cart A was conducted with LVN 1. A box of budesonide (medication used to reduce irritation and swelling of the airways) inhalation solution 0.5 mg/2 ml was observed. Inside the box was an open foil package dated [DATE], with two ampules remaining. The medication box showed once the foil envelope was opened, use the ampules within two weeks. LVN 1 reviewed the medication box instructions and verified the remaining medication in the opened foil envelope should have been removed from the cart. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>39453<br><br>Based on observation, interview, and facility document review, the facility failed to follow the menu.<br><br>*Cook 1 did not follow the recipe when preparing pureed Spinach Au Gratin (creamed spinach topped with cheese and baked in the oven)<br><br>*Scoop #12 was used to serve regular Spinach Au Gratin instead of scoop #8 per the spreadsheet.<br><br>These failures had the potential of the menu not meeting the residents' nutritional needs which could lead to nutritional related health complications.<br><br>Findings:<br><br>Review of the Order Listing Report dated 6/3/24, showed eight residents were on pureed diet, and 68 residents on regular diet, with no restrictions to vegetable or spinach or cheese.<br><br>1. Review of the facility's document titled Summer Menus for Week 1 Tuesday dated 6/4, 7/2, 7/30, and 8/27/24, for lunch showed to serve Spinach Au Gratin for lunch.<br><br>Review of the facility's document titled Recipe: Spinach Au Gratin, Week 1 Tuesday showed to cook spinach in enough water to cover, drain well and place in baking pan. Add margarine and cheese and mix well.<br><br>On 6/4/24 at 1029 hours, an observation of the pureed food preparation and concurrent interview was conducted with [NAME] 1. During the pureed vegetable preparation, [NAME] 1 was observed taking a silver container with spinach. [NAME] 1 stated the spinach was boiled with soup base. [NAME] 1 continued to puree the spinach and added thickener to the pureed recipe. [NAME] 1 was observed placing the pureed spinach into the oven. When asked if anything was added or to be added to the spinach, [NAME] 1 answered no.<br><br>On 6/4/23 at 1100 hours, an interview and concurrent facility document review was conducted with [NAME] 1 and the DSS. [NAME] 1 and the DSS verified the above findings.<br><br>2. Review of the facility's document titled Summer Menus for Week 1 Tuesday dated 6/4, 7/2, 7/30, and 8/27/24, for lunch, showed to serve 1/2 cup of Spinach Au Gratin for regular diet (small, regular, large portions), and also for mechanical soft diet.<br><br>Review of the facility's document titled Portion Control Chart (undated) showed to control accurate food costs and find the correct disher/ scoop utensil for the serving size. The chart showed for 1/2 cup serving size to use disher/ scoop size #8 (gray).<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/4/24 at 1150 hours, a trayline observation with [NAME] 1, and concurrent interview and concurrent traycart inspection was conducted with the DSS. [NAME] 1 was observed using disher/ scoop size #12 to serve Spinach Au Gratin for regular diet. A traycart was observed near the kitchen door. The DSS stated the trays in the cart were ready to be delivered to the residents. During the traycart inspection, several trays were observed with Spinach Au Gratin for residents on regular diet and mechanical soft diet. When asked about the scoop used for regular Spinach AuGratin, the DSS verified the serving size was not what was stated on the spreadsheet for the regular Spinach AuGratin. The DSS acknowledged [NAME] 1 should have used #8 scoop instead of #12 scoop to serve the regular Spinach Au Gratin. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>39453<br><br>Based on observation, interview, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by:<br><br>* The facility failed to ensure proper labeling and dating of foods in the kitchen.<br><br>*The facility failed to ensure the food items inside the refrigerator used for residents' food brought in from outside were properly stored per the facility's P&P.<br><br>* The ice machine was dirty with yellowish slimy residue in the upper inside part of the ice maker area.<br><br>* The kitchen exhaust hood was observed with brownish black residue.<br><br>* The facility failed to ensure the proper sanitary condition of the kitchen equipment. The oven and heated plate dispenser were observed with food debris.<br><br>* The facility failed to ensure the kitchen items were air dried.<br><br>* The facility failed to ensure cutting boards were kept in a sanitary condition.<br><br>These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared in the kitchen.<br><br>Findings:<br><br>Review of the facility's document titled Order Listing Report dated 6/3/24, showed 71 of 72 residents in the facility received food prepared in the kitchen.<br><br>1. According to FDA Food Code 2022, Section 3-501.17, Ready-To-Eat, Time/Temperature Control for Safety Food, Date Marking, showed date marking requirements apply to containers of processed food that have been opened and to food prepared, if held for more than 24 hours, by marking the date or day the original container is opened with a procedure to discard the food on or before the last date by which the food must be consumed.<br><br>Review of the facility's P&P titled Food Storage revised date 7/25/19, showed food items will be stored, thawed, and prepared in accordance with good sanitary practice. All times will be correctly labeled and dated.<br><br>On 6/3/24 at 0805 hours, during the initial tour of the kitchen, a bag of frozen egg omelets, a bag of frozen smores doodle cookies, a bag of frozen donuts and a bag of frozen blueberries were observed with no opened date inside Freezer #2. The DSS verified the above findings.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of the facility's P&P titled Food Brought In by Visitors revised 6/2018 showed when food is brought into a nursing home prepared by others, the nursing home is responsible for ensuring that the food container is clearly labeled with the resident's name and date received and stored in a refrigerator designated for this purpose.<br><br>a. On 6/5/24 at 0734 hours, an inspection of the refrigerator used for residents' food brought in from outside was conducted with LVN 3. The following was observed inside the freezer:<br><br>-A box of chimichangas was observed labeled with resident name, and DD 6/2/24; and<br><br>-Four unlabeled bags of ice.<br><br>LVN 3 verified the above findings. LVN 3 stated DD meant due date, and the bags of ice were for a resident who brought his own ice.<br><br>b. On 6/5/24 at 1131 hours, several fruits and unlabeled food containers were observed on the Resident 58's bedside table, overbed table, floor, and on the bed.<br><br>On 6/5/24 at 1203 hours, an observation and concurrent interview was conducted with CNA 2. Several fruits and unlabeled food containers were observed on Resident 58's bedside table, overbed table, floor, and on the bed. CNA 2 verified the above findings. CNA 2 stated the facility was aware of the food containers, and fruits brought in by the resident's family members.<br><br>On 6/5/24 at 1211 hours, an interview and concurrent observation was conducted with LVN 3. LVN 3 verified the above findings.<br><br>Cross-reference to F813.<br><br>3. On 6/4/24 at 0803 hours, an ice machine inspection, concurrent interview, and facility document review was conducted with the Director of Maintenance. The upper inside cabinet layer of the ice machine was wiped with a white paper towel and a yellowish slimy residue was observed on the paper towel. The Director of Maintenance verified the above findings. When asked what solutions were used to clean the ice machine, the Director of Maintenance stated he used two solutions, to which he showed a bottle of Hydro Balance H. B. 30 ice machine cleaner nickel-safe, and a green bottle and labeled only with for ice machine only.<br><br>Cross-reference to F908.<br><br>4. According to DA Food Code 2022, 4-602.13, Non-Food Contact Surfaces, showed the presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests.<br><br>Review of the facility's P&P titled Hood and Filter-Operation and Cleaning dated 10/1/14, showed the hood and filter system will be cleaned routinely at least weekly or more often as necessary, and hoods will be kept free of grease and dust.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/3/24 at 0805 hours, during an initial tour of the kitchen, a brownish black residue was observed on the hood vent, a teardrop-shaped brownish liquid was observed on the cable part of the hood, and a brownish residue was observed on the tube sticking out of the hood. The DSS verified the above findings. The DSS stated the hood/vent system deep cleaning was scheduled every six months by an outside vendor, and the hood/ vent system was last cleaned on December 2023.<br><br>5. According to FDA Food Code 2022, 4-601.11, Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils, showed the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.<br><br>On 6/3/24 at 0805 hours, during the initial tour of the kitchen, the following was observed:<br><br>-A black residue was observed on the bottom oven;<br><br>-Several food debris and pieces of aluminum foil were observed underneath the oven;<br><br>-Several food debris were observed on the inner bottom of the heated plate dispenser; and<br><br>-Several food debris were observed on the blender machine.<br><br>The DSS verified the above findings.<br><br>6. According to FDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, showed after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before contact with food.<br><br>According to FDA Food Code 2022, 4-903.11, Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, showed cleaned equipment and utensils shall be stored in a self-draining position that allows air drying.<br><br>a. On 6/3/24 at 0805 hours, during the initial tour of the kitchen, the blender container was observed stored with water residue inside the container. The DSS verified the above finding.<br><br>b. On 6/4/24 at 1029 hours, a pureed food observation was conducted with [NAME] 1, with the DSS present. After pureeing the beef, a dietary staff was observed taking and washing the blender container and measuring cup. [NAME] 1 was observed taking the blender container and measuring cup and was observed using a paper towel to dry the blender container and measuring cup. [NAME] 1 and the DSS verified the above findings.<br><br>7. According to FDA Food Code 2022, Section 4-501.12, Cutting Surfaces, showed surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.<br><br>On 6/5/24 at 0805 hours, two green cutting boards were observed to be heavily marred with knife marks. The DSS verified above findings. |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to follow the P&P for the resident's food brought by the visitors for one of 18 final sampled residents (Resident 58).<br><br>* The facility failed to ensure the safe food handling guidelines were implemented to the resident's family/visitors who brought the resident food from the outside. In addition, the facility failed to provide resident and family with the P&P about the use and storage of brought in by family and visitors as part of their admission packet as per the facility's P&P.<br><br>These failures had the potential for unsafe food handling and may cause foodborne illness to the residents who received food brought by the visitors.<br><br>Findings:<br><br>Review of the facility's P&P titled Food Brought In by Visitors revised 6/2018 showed when food is brought into a nursing home prepared by others, the nursing home is responsible for ensuring that the food container is clearly labeled with the resident's name and date received and stored in a refrigerator designated for this purpose, and provide resident and family with the P&P about the use and storage of brought in by family and visitors as part of their admission packet.<br><br>On 6/5/24 at 1131 hours, several fruits and unlabeled food containers were observed on the resident's bedside table, overbed table, floor, and on the bed.<br><br>Medical record review for Resident 58 was initiated on 6/3/24. Resident 58 was readmitted to the facility on [DATE].<br><br>Review of Resident 58's plan of care dated 5/17/24, showed a care plan problem to address family and resident bringing extra food from home and keeps under the bed, bedside drawer and bedside table. The interventions included to provide education to resident and family regarding infection control, to continue to communicate to resident and family about bringing extra food at bedside, and to continue to offer the resident bridge as a form of storage.<br><br>Review of Resident 58's Progress Notes dated 5/17/24 at 1505 hours, showed the MDS Coordinator called Resident 58's family member regarding extra food at bedside including the drawers, table, and under the bed, informed about extra food at bedside was bed stored in containers with lid for infection prevention purposes, and offered resident refrigerator as means of storage.<br><br>Further review of Resident 58's medical records did not show the staff continued to communicate to resident and family about bringing and storing the extra food. Further review, there was no documentation to show follow-up regarding family members bringing and storing the extra food for Resident 58.<br><br>(continued on next page) |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/5/24 at 1203 hours, an observation and concurrent interview was conducted with CNA 2. Several fruits and unlabeled food containers were observed on the resident's bedside table, overbed table, floor, and on the bed. CNA 2 verified the above findings. CNA 2 stated the facility was aware of the food containers, and fruits brought in by the resident's family members.<br><br>On 6/5/24 at 1211 hours, an interview and concurrent medical record review for Resident 58 was conducted with LVN 3. LVN 3 verified the above findings. LVN 3 stated the MDS Coordinator spoke with Resident 58 and her family members.<br><br>On 6/5/24 at 1218 hours, an interview and concurrent medical record review for Resident 58 was conducted with the MDS Coordinator. The MDS Coordinator stated she called Resident 58's family member regarding extra food at bedside. The MDS Coordinator stated during the last visit of Resident 58's family member, he stated he would bring food container. When asked if she conducted a follow-up, the MDS Coordinator verified she did not follow-up with the family members bringing and storing the extra food for Resident 58.<br><br>On 6/6/24 at 1018 hours, an interview and concurrent medical record review for Resident 58 was conducted with the Admissions Director. When asked if she communicated to the residents or their family members, during admission, regarding bringing in food from outside, the Admissions Director stated she would only communicate regarding bringing in food from outside to the resident or the family members only if the resident or family members asked about it. When asked if the policy about the use and storage of brought in by family and visitors was provided to the residents or their representative as part of their admission packet, the Admission Director stated the policy should be part of their admission packet. When asked for a documentation of the policy about the use and storage of brought in by family and visitors provided to Resident 58 and/ or representative, the Admission Director showed Resident 58's Admission Agreement.<br><br>Review of Resident 58's Admission Agreement dated 2/22/23, under Attachment G: Snacks, showed to make sure all food or snacks left with the resident are stored in a sealed Tupperware-like container. The charge nurse must be notified in advance of any meals that will be brought in for the resident.<br><br>Further review of Resident 58's Admission Agreement, and admission packet, did not show the policy about the use and storage of brought in by family and visitors was provided to Resident 58 and/ or representative, as part of the admission packet.<br><br>The Admissions Director verified the above findings.<br><br>Cross-reference to F812 example #2b. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Dispose of garbage and refuse properly.<br><br>39453<br><br>Based on observation, interview, and facility P&P review, the facility failed to dispose of trash properly. One of three dumpsters was observed overflowing with boxes, which prevented the lid from fully closing. This had the potential to attract and harbor pests and/ or rodents.<br><br>Findings:<br><br>According to FDA Food Code 2013, 5-501.113, Covering Receptacles, receptacle and waste handling units for refuse, recyclables, and returnables shall be kept covered with tight-fitting lids.<br><br>On 6/4/24 at 0755 hours, three dumpsters and one food waste bin were observed outside adjacent to the facility. One dumpster was observed with the lid propped open by boxes, which prevented the lid from fully closing.<br><br>On 6/4/24 at 0803 hours, an observation of trash disposal and concurrent interview was conducted with the Director of Maintenance. One of three dumpsters outside adjacent to the building was observed overflowing with boxes and the lid was not fully closed. The Director of Maintenance verified the findings. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683<br><br>Based on observation, interview, medical record review and facility document review, the facility failed to maintain accurate and confidential resident records.<br><br>* The facility failed to ensure confidential resident rosters were not included in the CDPH Survey results binder for public review.<br><br>* The facility failed to ensure Resident 29's monthly weight was documented correctly.<br><br>These failures had the potential for protected information to be viewed by the public and the resident's care needs not being met as the medical information was incomplete and inaccurate.<br><br>Findings:<br><br>1. On 6/5/24 at 0926 hours, a binder labeled CDPH Annual Survey Binder was observed on a table in the lobby for public review. Review of the binder showed the following confidential resident rosters:<br><br>- a confidential resident roster dated 8/31/21, with two residents' names and their identifiers<br><br>- a confidential resident roster dated 9/1/21, with two residents' names and their identifiers<br><br>- a confidential resident roster dated 9/15/21, with two residents' names and their identifiers<br><br>On 6/5/24 at 0937 hours, an interview and concurrent facility document review were conducted with the Administrator. The Administrator verified three confidential resident rosters were in the CDPH Annual Survey Binder and should not have been there.<br><br>39670<br><br>2. Medical record review for Resident 29 was initiated on 6/4/24. Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE].<br><br>Review of Resident 29's monthly weights for the past six months, showed the following monthly weights:<br><br>- On 1/5/24 = 165.0 lbs<br><br>- On 2/1/24 = 169.1 lbs<br><br>- On 4/8/24 = 159.9 lbs<br><br>- On 5/3/24 = 161.7 lbs<br><br>- On 6/1/24 = 70.6 lbs<br><br>(continued on next page) |

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| | 056362 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Further review of the medical record failed to show documented evidence Resident 29 had significant weight loss.<br><br>On 6/6/24 at 1055 hours, an interview and concurrent medical record review for Resident 29 was conducted with the DON. The DON stated she entered the monthly weight results in the electronic medical records. The DON verified the monthly weight data results were entered in error. The DON verified the monthly weight results for June was entered in kilograms and it should have been converted into pounds. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>32179<br><br>Based on observation and interview, the facility failed to ensure the appropriate infection control practices were implemented to provide a safe and sanitary environment and prevent the spread of infections within the facility.<br><br>* There were multiple briefs and blue chucks stacked on the top of an isolation chart located in front of room A.<br><br>This failure posed the risk of transmission of infectious organisms from the floor to the residents in the facility.<br><br>Findings:<br><br>On 6/5/24 at 0410 hours, multiple briefs and blue chucks were observed stacked on the top of the isolation cart.<br><br>On 6/5/24 at 0515 hours, CNA 3 took the briefs and chucks to be distributed to rooms A, B, and Resident 18's room.<br><br>On 6/5/24 at 0520 hours, an interview was conducted with CNA 3. CNA 3 stated she put the briefs and chucks there to distribute them to different residents. CNA 3 acknowledged the briefs and chucks should not be placed on the top of isolation cart due potential contamination and spread of infection. CNA 3 verified the findings. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>39453<br><br>Based on observation, interview, facility document review, equipment instruction manual review, and facility P&P review, the facility failed to maintain the essential equipments in safe operating condition.<br><br>* The facility failed to ensure the ice machine was cleaned and sanitized according to the manufacturer's specification, and per the facility's P&P. An incorrect ratio of the nickel-safe cleaner was used to descale the ice machine, a hot water instead of a sanitizing solution was used to sanitize the inside of the machine, and an unidentified and unlabeled spray bottle was used to sanitize the panels of the ice machine. These failures had the potential for the equipment to not function in the way it was intended, which could cause food-borne illnesses for the residents.<br><br>* The glucometer in Medication Cart A's serial number did not match the glucometer serial number listed on the Quality Control Record. This failure post a risk for incorrect blood sugar reading resulting to incorrect blood sugar management that can negatively affect the resident's well-being.<br><br>Findings:<br><br>1. Review of the facility's document titled Order Listing Report dated 6/3/24, showed 71 of 72 residents in the facility received food prepared in the kitchen.<br><br>According to FDA Food Code 2022, Section 4-501.11, Good Repair and Proper Adjustment, showed the proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk.<br><br>Review of the Ice-O-Matic Installation Guide and Owner's Manual dated 02/2020, under the Cleaning Instruction for Ice-O-Matic CIM Series Ice Machines section, showed the following:<br><br>-Proper cleaning of an ice machine requires two parts: descaling and sanitizing. Descaling should be scheduled at a minimum twice per year but no more than once a month;<br><br>-Descaling dissolves the mineral deposits on the evaporator and other surfaces. It removes scale, calcium, lime scale and other mineral buildup. Ice-O-Matic requires nickel safe cleaner such as Nu-Calgon Nickel-Safe Ice Machine Cleaner or equivalent diluted per manufacturer's instruction;<br><br>-Sanitizing should be performed after each descaling but no more than once per month. Sanitizing disinfects the machine and removes microbial growth including mold and slime. Ice-O-Matic requires a nickel-safe sanitizer such as Nu-Calgon IMS-III or equivalent diluted per manufacturer's instructions;<br><br>(continued on next page) |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Measure the appropriate amount of descaler according to the machine size and sump volume from chart. The manual showed a chart for different Ice-O-Matic model numbers, sump size gallons, and examples of descaler concentration ratio of five fluid ounce per one gallon of water (or 39 ml per one liter of water), and the sanitizer concentration ratio of 1.6 fluid once per one gallon of water (12.5 ml per one liter of water) and to add more according to the ice machine model; and<br><br>-Sanitizing the ice machine is recommended after descaling. Repeat the process with sanitizer at correct ratio.<br><br>Review of the facility's P&P titled Ice Machine - Operation and Cleaning revised date 10/1/14, showed the following:<br><br>-Wash the inside of the machine using pot and pan washing solution and rinse well;<br><br>-Sanitize the inside of the machine using a sanitizing solution and a clean cloth;<br><br>-Allow the inside of the machine to air dry, then refill the machine with ice; and<br><br>-Maintenance staff will clean the ice making mechanism according to manufacturer's guidelines.<br><br>Review of the facility's document titled Preventative Maintenance Ice Machine for 2024 showed an outside vendor performed the quarterly cleaning service on 4/29/24.<br><br>On 6/4/24 at 0803 hours, an inspection of the ice machine and concurrent interview and facility document review was conducted with the Director of Maintenance. The upper inside cabinet layer of the ice machine was wiped with a white paper towel and a yellowish slime was observed on the paper towel. The Director of Maintenance verified the above finding. When asked how often the ice machine was cleaned and sanitized, the Director of Maintenance stated he cleaned and sanitized the ice machine monthly, and quarterly by an outside vendor. When asked how he cleaned and sanitized the ice machine, the Director of Maintenance stated he removed the front panel of the ice machine covering the area where the ice was made, and the ice storage bin door. When asked what solution he used to clean the ice machine, the Director of Maintenance stated he used a capful of the nickel-safe ice machine cleaner (using the bottle cap) diluted with a little bit of water, to which he showed a bottle of H.B. 30 nickel safe ice machine cleaner. Upon inspection of the bottle of H.B. (Hydro Balance) 30 nickel safe ice machine cleaner, the directions for use section, showed to add H. B 30 to circulating water at the rate of three to six ounces per gallon of water. When asked what he used to sanitize the ice machine, the Director of Maintenance stated he used hot water to clean the inside of the ice machine and used the sanitizer spray only to the panels of the ice machine, to which he showed a green spray bottle. Upon inspection of the green spray bottle, the spray bottle was labeled only with for ice machine only sticker, and the spray bottle did not show any brand, nor a label to show if it was the correct sanitizer solution for the ice machine. The Director of Maintenance stated the green spray bottle was provided by the outside vendor but did not know what brand it was. The Director of Maintenance verified he did not follow the correct procedure and correct ratio of the solutions per the manufacturer's specifications, and per the facility's P&P.<br><br>39683<br><br>(continued on next page) |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of the facility's P&P titled P-NP16 Blood Glucose Monitoring reviewed 4/27/23, showed a glucometer quality control check will be performed at least once every 24 hours, and to document the results in the quality control log.<br><br>Review of the facility's Order List Report for Medication Cart A dated 6/6/24, showed three residents had routine glucometer checks.<br><br>On 6/4/24 at 1416 hours, an inspection of the Medication Cart A was conducted with LVN 1. Review of the glucometer Quality Control Record for June 2024, showed the daily Quality Control (QC) testing was completed for a glucometer machine with the serial number 1040-425000016. However, the Assure Platinum glucometer machine stored in the medication cart showed a serial number 1040-4039524. LVN 1 verified the serial numbers for the glucometer machine in the medication cart did not match the serial number in the control log. LVN 1 stated it should match.<br><br>On 6/6/24 at 0836 hours, an interview was conducted with the DON. The DON stated the glucometer serial number on the QC log should match the glucometer machine serial number in the medication cart. |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670<br><br>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurate, complete and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of bed rails for all three residents (Residents 18, 50, and 423) with side rails. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death.<br><br>Findings:<br><br>According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are:<br><br>- Zone 1: within the rail;<br><br>- Zone 2: under the rail, between the rail supports or next to a single rail support;<br><br>- Zone 3: between the rail and the mattress;<br><br>- Zone 4: under the rail, at the ends of the rail;<br><br>- Zone 5: between split bed rails;<br><br>- Zone 6: between the end of the rail and the side edge of the head or foot board; and<br><br>- Zone 7: between the head or foot board and the mattress end.<br><br>Review of the facility's P&P titled Bed Rails revised 11/16/22, showed for the purpose of this policy bed rails include side rails, safety rails, and grab or assist bars. Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail, and mattresses will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the FDA. Maintenance staff routinely inspects all bed and related equipment to identify risks and problems including potential entrapment risks. The maintenance department provides a copy of inspection to the administrator and report results to the QAPI committee for appropriate actions. Copies of the inspection results and QAPI committee recommendations are maintained by the administrator and/or safety committee.<br><br>(continued on next page) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility documents showed the facility had three residents with the use of side rails.<br><br>A concurrent observation, medical record review, and facility document review for Residents 18, 50, and 423 showed the residents' bed entrapment assessments were not accurate, completed, or the bed inspection gap measurements were not recorded from bed to side rail or bed headboard to siderail. For example:<br><br>1. On 6/3/24 at 1054 hours and 6/4/24 at 0819 hours, Resident 50 was observed lying in bed with both upper side rails were elevated.<br><br>Medical record review for Resident 50 was initiated on 6/4/24. Resident 50 was admitted to the facility on [DATE].<br><br>Review of Resident 50's H&P examination dated 5/16/24, showed Resident 50 did not have capacity to understand and make decisions.<br><br>Review of Resident 50's Bed Rail assessment dated [DATE], showed bilateral side rails were used for mobility and safety.<br><br>On 6/5/24 at 0920 hours, an interview for Resident 50 was conducted with CNA 7. CNA 7 verified Resident 50's use of upper side rails. CNA 7 stated the resident was able to hold the rails while providing care but unable to pull herself up.<br><br>2. On 6/3/24 at 1056 hours an 6/4/24 at 0958 hours, Resident 423 was observed in bed with both upper side rails elevated.<br><br>Medical record review for Resident 423 was initiated on 6/3/24. Resident 423 was admitted to the facility on [DATE].<br><br>Review of Resident 423's Order Summary Report dated 6/4/24, showed a physician's order dated 5/29/24, for bilateral side rails for bed mobility and positioning.<br><br>Review of Resident 423's Bed Rail assessment dated [DATE], showed bilateral side rails were used for mobility and safety.<br><br>On 6/5/24 at 1118 hours, an interview for Resident 423 was conducted with CNA 2. CNA 2 verified Resident 423's use of upper side rails. CNA 2 stated the resident was able to use the side rails for repositioning and turning.<br><br>On 6/4/24 at 1429 hours, an interview and concurrent facility document review for Resident 50 and 423 was conducted with the Maintenance Director. The Maintenance Director stated he was responsible to do the entrapment risk assessment of the facility's beds with side rails. The Maintenance Director stated he had the list of the beds with side rails assessed for entrapment. The Maintenance Director was able to show the blank Bed System Measurement Device Test Results Worksheet form. However, the Maintenance Director could not provide the documentation if the bed inspection and entrapment risk assessment were performed for the beds with side rail.<br><br>(continued on next page) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/6/24 at 1046 hours, an interview was conducted with the DON. The DON was informed of the above findings and verified the findings.<br><br>32179<br><br>3. Medical record review of Resident 18 was initiated on 6/3/24. Resident 18 was admitted to the facility on [DATE] and readmitted on [DATE].<br><br>Review of Resident 18's H&P examination dated 4/3/24, showed Resident 18 had fluctuating capacity to understand and make decisions.<br><br>Review of Resident 18's Bed Rail assessment dated [DATE], showed the side rails or assist bars indicated and serve as an enabler to promote independence.<br><br>Review of Resident 18's Plan of Care dated 5/16/24, showed a care plan problem to address Resident 18 use of the bilateral upper quarter siderails for ADL changes, mobility, positioning and as an enabler. The interventions included to discuss and record with the resident family or caregivers the risk and benefits of the restraint when the restraints should or will be applied, the routines while restrained, and any concern or issues regarding restraint issues.<br><br>On 6/3/24 at 0910 hours and 6/3/24 at 1215 hours, Resident 18 was observed lying in bed with the bilateral upper bed rails elevated (from head to elbow).<br><br>On 6/4/24 at 1430 hours, an interview and concurrent record review for Residents 18 was conducted with the Maintenance Director. The Maintenance Director stated he was responsible for the bed inspection including inspecting, and installing the bed rails after he received the request from the nurses to install the bed rails. The Maintenance Director was asked to provide documentation for entrapment assessment. The Maintenance director acknowledged he did not do any entrapment assessment. The maintenance Director verified the above findings.<br><br>On 6/6/24 at 1100 hours, the Environmental Services Staff was summoned to Resident 18's room. The Environmental Services Staff measured the side rail length and width and it was 20.5 inches by 10 inches. The Environmental Services Staff acknowledged that the gap with length and width of 3 inch x 7 inch could possibly entrapped the arm and hand. The Environmental Services Staff verified the findings. |