STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555187	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catalina Island Medical Center D/P Snf	100 Falls Canyon Rd Avalon, CA 90704

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview, and record review, the facility failed to implement a baseline care plan for two of three sampled residents (Residents 1 and 2) who were taking Melatonin (a non-pharmaceutical sleep aid) for sleep difficulty. This deficient practice had the potential to place the residents at risk for prolonged sleep. A. During a review of Resident 2's Admission record, the Admission Record indicated Resident 2 was admitted on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with everyday activities) with agitation, insomnia (difficulty falling asleep, staying asleep, or getting good quality sleep), unsteady gait (walking), and hypertension (high blood pressure). During a review of Resident 2's Minimum Data Set (MDS), a standardize assessment and care planning tool dated 4/7/2024, the MDS indicated Resident 2 was cognitively (mental action or process of acquiring knowledge and understanding ability) moderately intact and required supervision sit to lying, lying to sitting, bathing, required setup assistance in eating, performing oral hygiene, toileting, dressing, personal hygiene, and is independent in ambulating and transferring. The MDS indicated Resident 2 has functional limitation bilaterally (both sides) on the lower (legs, hip) extremities and utilized a cane for ambulating. During a record review of Resident 2 medical records, the records indicated a physician's order dated 4/9/2024 for Melatonin oral tablet 10 milligrams (mg a unit of measure of weight) by mouth every 16 hours (hrs) as needed for sleep difficulty. During a review of Resident 2's Care Plan (CP), there were no CP's or interventions related to sleep difficulty. During a review of the Medication Administration Record (MAR: document that details medications administered to the patients), the MAR indicated that Resident 2 received Melatonin 10mg every day from 4/17/2024 to 5/7/2024. (continued on next page)

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/9/2024 at 2:37p.m. Registered Nurse 2 (RN 2) stated care plans are initiated on admission and are updated when there is a change of condition and quarterly. RN 2 stated care plans are kept up to date for each resident to reflect the current care that is given and ensure the interventions are implemented as stated on the care plan. During a concurrent interview and record review on 5/10/24 at 12:13p.m., Licensed Vocational Nurse 2 (LVN 2) stated Resident 2 did not have a care plan for sleep and the sleeping patterns should be documented for residents that are on sleeping medications to see if the medication is working. During a concurrent interview and record review on 5/10/2024 at 2:02p.m. the Director of Nursing (DON) stated residents will need a care plan for sleep to reassess the resident to ensure they are not over sleeping and see if the dose or the order needs to be changed. B.During a review of Resident 1's Admission record, the Admission Record indicated Resident 1 was admitted on [DATE] with diagnoses that included post-traumatic stress disorder, chronic (a mental health condition that can develop after experiencing or witnessing a traumatic event), psychotic disturbance (a mental disorder characterized by disconnection from reality), dementia (impaired ability to remember, think, or make decisions that interferes with everyday activities), mood disturbance (causes a person to experience extreme happiness, sadness, or both for long periods of time and generalized anxiety disorder (a condition in which a person has excessive worry and feelings of fear , dread, and uneasiness). During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 was cogitatively intact. The MDS inciated Resident 1 required set up or clean- up assistance with oral hygiene, toileting hygiene , upper body dressing (the ability to dress and undress above the waist, including fasteners, if applicable) and lower body dressing (the ability to undress below the waist, including fasteners, does not include footwear). During a record review of Resident 1 medical record, the medical record indicated a physician's order dated 12/31/2023 and discontinued on 4/7/2024, for Melatonin oral tablet 3 mg by mouth every 24 hours as needed for insomnia (a sleep disorder that makes it difficult to fall asleep) During a review of Resident 1's Care Plan (CP), there were no CP's or interventions related to sleep difficulty. During a review of the MAR, Resident 1 received Melatonin 3 mg on 4/7/2024. During a concurrent interview and record review on 5/10/2024 at 09:14 a.m., with the Licensed Vocational Nurse 1(LVN), LVN 1 stated the resident does have a problem with sleeping at night and has an order for melatonin to help with sleep. LVN 1 stated because resident has problems with sleep this needs to be care planned to make sure he gets the right level of care. During a concurrent interview and record review on 5/10/2024 at 1:12 p.m., with the Director of Nursing (DON) , the DON verified there was no care plan for insomnia and stated not being able to sleep is a change of status and needs to be care planed. DON stated care plan helps in monitoring if the medication is effective or not. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Comprehensive Care Plan dated 5/31/2023, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to ensure a resident was free from unnecessary drugs for one of three sampled residents (Residents 2) by not monitoring the specific behavior manifestation according to the prescribed antipsychotic (medication used to treat severe mental illness) medication dose ordered. This deficient practice had the potential to result in over use of an antipsychotic medication, without monitoring for the effectiveness and/or ineffective of the medication and can lead to adverse drug reactions. During a review of Resident 2's Admission record) the Admission Record indicated Resident 2 was admitted on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with everyday activities) with agitation, insomnia (difficulty falling asleep, staying asleep, or getting good quality sleep), unsteady gait (walking), and hypertension (high blood pressure). During a review of Resident 2's Minimum Data Set (MDS), a standardized assessment and care planning tool dated 4/7/2024, the MDS indicated Resident 2 was cognitively (mental action or process of acquiring knowledge and understanding ability) moderately intact and required supervision sit to lying, lying to sitting, bathing, required setup assistance in eating, performing oral hygiene, toileting, dressing, personal hygiene, and is independent in ambulating and transferring. aspects of activities of daily living (ADL: personal hygiene, toileting, bathing, dressing). The MDS indicated Resident 2 had potential indicators of psychosis (a disorder that causes loss of contact with reality) such as hallucinations (an experience involving the apparent perception of something not present.) and delusions (a false belief or judgment about external reality), as well as verbal behavioral symptoms, (threatening others, screaming at others), directed towards staff. The MDS indicated Resident 2 is on antipsychotic medications. The MDS indicated resident's current behavior had gotten worse. The MDS indicated Resident 2 has functional limitation bilaterally (both sides) on the lower (legs, hip) extremities and utilized a walking cane for ambulation. During a review of the provider note dated 4/24/2024 at 4:26p.m., the Provider Note indicated that Resident 2 was sent to the emergency department due to an aggressive outburst towards staff that required medication (for aggressive psychotic episodes). Resident 2 received Haldol (an antipsychotic medication) five milligrams (a unit of measure of weight) intramuscular injection (IM: medication administered by needle deep into the muscles), and once evaluated by a psychiatric nurse practitioner, the order was changed to Haldol 1 mg twice a day and use Ativan as needed for agitation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the Order Summary Report (Physician Orders) dated 4/24/2024, the physician's order indicated an order for Haloperidol (also known as Haldol: treat nervous, emotional, and mental conditions) oral tablet 1 mg by mouth two times a day for psychosis per psychiatry recommendation, and an order for Ativan (used to manage anxiety disorders, insomnia, panic attacks) oral tablet 0.5mg (Lorazepam) by mouth every six hours as needed for agitation. There were no orders to monitor Resident 2 for adverse reactions from the medications or medications effectiveness on Resident 2's psychotic behaviors. During a review of the Medication Administration Record (MAR: document that details medications administered to the patients), Resident 2 had an order dated 3/2/2024 and discontinued on 4/9/2024 to receive Seroquel (medication used to treat depressive and manic episodes) oral tablet 12.5mg by mouth two times a day for hallucinations, agitation and anxiousness related to dementia. Seroquel 12.5mg two times a day for hallucinations related to dementia was resumed on 4/9/2024 and was discontinued on 4/24/2024. Additionally, Resident 2 had an order for Seroquel 12.5mg by mouth every 24 hours as needed (PRN) for agitation/fear from 4/9/2024 to 4/24/2024. Resident 2 had received Seroquel 12.5mg PRN on 4/16/2024 at 7:07p.m., 4/18/2024 at 6:49 a.m. and 6:16p.m. During an interview on 5/9/2024 at 2:46p.m. with RN 2, RN 2 stated residents who are on psychotropic medications (antidepressants (treat depression), anti-anxiety medications, antipsychotics, and mood stabilizers) should be monitored for signs and symptoms of suicidal ideation or if they are a threat to others or self as something bad could happen to the resident, if you do not feel well you do not act well, and it is important to help stabilize the resident to become less paranoid, or have less hallucination and delusions. RN 2 stated if the correct psychotropic medications are not given, the medication needs to be adjusted, monitored, and the physician needs to be notified if changes in medication or dosage are necessary. During an interview on 5/9/2024 at 4:34p.m. with the Pharmacist (PharmD), PharmD stated Resident 2 is on the minimal dose of Haldol 1mg twice a day. PharmD stated Haldol 1mg was started to treat agitation rather than for psychosis. PharmD stated the pharmacist will review the medication and check the indication (reason for administration) prior to having it dispensed. PharmD stated medications (indication and dosages) are reviewed every month and will indicate whether the medication needs to be reduced based on the residents' condition. PharmD stated some of the side effects for Haldol included dizziness, cause sedation with a higher dose, and can also cause tardive dyskinesia (muscle stiffness), so the residents should be monitored, and the electronic MAR should be equipped with a section where the nurses document the vital signs. PharmD stated monitoring the resident for side effects and effectiveness is a must and is nonnegotiable. During an interview on 5/10/2024 at 9:05a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 2 had episodes of sundowning at night (restlessness, agitation, irritability, confusion that gets worse as the evening sets in), had become aggressive, and will hit her cane on the floor. LVN 2 stated if Resident 2 is having behavioral issues, it will be documented in the behavioral note, however there is no place to document her behaviors on the MAR. LVN 2 stated Resident 2 does not have a section to tally her behavior, but it would be helpful to be able to track her behavior. LVN 2 stated tallying the behavior will help identify whether the medication is effective/not effective or if it is benefiting the resident. LVN 2 stated without tallying the behavior, they would not know whether the medication dose is appropriate or identify the purpose of giving the medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/10/2024 at 12:57p.m. with the Director of Nursing (DON), the DON stated the resident should be monitored to ensure the resident is safe and not harming themselves or others, they are not being treated with unnecessary psychotropic medications where behavior can be managed with the least restrictive measures as there are residents who sundown like Resident 2 with dementia that can exacerbate their condition. During an interview on 5/10/24 at 2:22p.m. with Psychiatric Nurse Practitioner (PNP), PNP stated the Resident 2 would have to be monitored to see if the behaviors are improving or not and would have to change the medication if it is not effective. During a review of the facility's P&P titled, Behavioral Assessment, Intervention and Monitoring dated 5/31/2023, the P&P indicated behavioral or psychological symptoms of dementia (BPSD) describes behavioral symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause. Current guidelines recommend the use of non-pharmacological interventions for BPSD. The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition, including: onset, duration, intensity and frequency of behavior symptoms, any recent precipitating or relevant factors or environmental triggers (e.g., medication changes, infection, recent transfer from hospital). When medications are prescribed for behavioral symptoms, documentation will include: monitoring for efficacy and adverse consequences. The IDT will monitor for side effects and complicated related to psychoactive medications; for example, lethargy, abnormal involuntary movements, anorexia, or recurrent falling. During a review of the facility's P&P titled, Dementia-Clinical Protocol dated 5/31/2023, the P&P indicated the staff and physician will evaluate individuals with new or worsening cognitive impairment and behavior and differentiate dementia from other causes. Individuals with dementia can also have a personality disorder, mental illness, psychosis, delirium, depression, and adverse drug reactions (ADRs), or other conditions causing or contributing to impaired cognition and problematic behavior.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45777 Based on observation, interview, and record review, the facility failed to ensure the storage, preparation and distribution of food was done under sanitary conditions by failing to: 1.Label open perishable food items on the kitchen shelves with the open-date. 2.Label open foods in the refrigerator with an open date. 3. Label open foods in Residents' refrigerator. This deficient practice placed the facility residents at risk for foodborne illness. Findings: On 5/ 8/ 2024 at 8:15 a.m., during an observation of the kitchen, the following was observed: 1.Baking powder and garlic salt 2 pounds 6 ounces food items were not labeled with an open-date. 2. The refrigerator contained a 1/2 gallon of milk , Salted Carmel Creamer, and planet oat milk 32 fluid ounce that were not labeled with an open-date. 3. The Residents' refrigerator contained 1/2 gallon of milk and 1 container of cottage cheese with no name (of whom it belonged to), or open-date. During an observation and interview on 5/8/2024 at 08:15 a.m., the Dietary Service Supervisor (DSS), stated he usually labels the foods with an open-date . The DSS stated he forgot to label the milk and creamer and stated the policy is when a food item is opened you must date all foods with an open-date so we can know when to throw them out. During an observation and interview on 5/9/2024 at 08:24 a.m., Food Service Worker 2 stated that in the resident's refrigerator there was a 1/2 gallon of milk opened and 1 container of cottage cheese with no date , name, or room number. FSW 2 verified the undated items and stated when residents' food prepared outside the facility comes in, we are to make sure the food is good we take the temperature of that food, put the residents name on it, and their room number. FSW 2 stated if the food item is opened we put the date it was opened on it. She further stated the reason for dating so you will know when the food items become bad and when to discard them. During a review of policies and procedures (P&P) titled FDA U.S. Food & Drug Administration, dated 2017 , the policy indicates refrigerated, Ready- to -eat Time/Temperature control for safety of foods prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold or discarded, based on the temperature and time combinations specified : (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.The day the original container is open in the food establishment is day 1and. 2.The day or date marked by the food establishment may not exceed a manufacture's use by date if the manufacture determines the use by date based on food safety. During a review of policies and procedures (P&P) titled Policy and Procedure , dated 1/1/2027 revised 1/1/2028 the policy indicates containers brought into the facility (community) by visitors should be labeled and dated.