| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 555209 | A. Building<br>B. Wing | 05/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Adventist Health Sonora - D/P Snf | 179 South Fairview Lane<br>Sonora, CA 95370 |

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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>43071<br><br>Based on observation, interview, and record review, the facility failed to ensure residents' right to a dignified existence was honored for 1 of 18 sampled residents (Resident 309), when Resident 309's urinary catheter bag (a drainage bag attached to a catheter (tube) that is inside the bladder to collect urine) was exposed and was not placed in a dignity bag (a bag used to the cover and hold the catheter drainage/collection bag so it is not visible) in the dining room.<br><br>This failure had the potential of emotional harm for Resident 309.<br><br>Findings:<br><br>During an observation on 5/7/24, at 1:14 PM, Resident 309 ate lunch in the dining room. Resident 309's urinary catheter bag was exposed, was not in a dignity bag, and was hanging on a walker.<br><br>During an interview on 5/7/24, at 1:18 PM, Licensed Nurse (LN) 7 stated residents who ate lunch in the dining room were alert. LN 7 confirmed Resident 309's urinary bag was not in a dignity bag in the dining room. LN 7 stated a resident's urinary bag had to be placed in a dignity bag for privacy. LN 7 further stated, People don't like other people see their bag with urine.<br><br>During an interview on 5/8/24, at 4:55 PM, the Director of Nursing (DON) stated the importance of keeping a urinary bag covered in a dignity bag was to provide residents' dignity. The DON further stated, People don't like to see urine, we don't carry our urine with us.<br><br>Review of a facility policy titled, URINARY CATHETERS, revised 5/24/23, indicated, .Catheter maintenance . Cover bag with clean pillow case or other covering for privacy and dignity .<br><br>Review of facility policy titled, RESIDENT RIGHTS, revised 5/23/23, indicated, .In accordance with the State and Federal Regulations, the facility adopts the list of resident rights (Resident [NAME] of Rights) .It is implied that this list may not be all inclusive and that rights whether on this list or not are respected .<br><br>(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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a facility document titled, RESIDENT BILL OF RIGHTS, dated 2/2009, indicated, .Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated .Patients shall have the right .To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs .Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality . |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>47369<br><br>Based on observation, interview, and record review, the facility failed to provide a home-like environment for two of eighteen sampled residents (Resident 47 and Resident 57), when Resident 47's personal items were displayed on Resident 57's side of the room and Resident 57's items were displayed on Resident 47's side of the room.<br><br>This failure had the potential to negatively impact Resident 47 and Resident 57's psychosocial well-being.<br><br>Findings:<br><br>1. A review of Resident 47's Resident Face Sheet, indicated, she was admitted to the facility in 2023, with diagnoses which included dementia.<br><br>A review of Resident 47's care plan dated 5/7/24, indicated, .Problem .memory/recall problem R/T [related to] dementia .avoid change in routine .Provide familiar items in room .<br><br>A review of Resident 47's care plan dated 5/2/24, indicated, .Psychosocial Well- Being .Actual or Potential Adjustment Impairment .Provide privacy, personal objects. Encourage family to bring items of personal meaning to increase comfort .<br><br>A review of Resident 47's clinical document titled, RESIDENT INCIDENT REVIEW, dated 5/1/24, indicated, . Trial bed [change] move from B bed to A bed .<br><br>2. A review of Resident 57's Resident Face Sheet, indicated, she was admitted to the facility in 2024.<br><br>A review of Resident 57's care plan dated 3/5/24, indicated, .Problem .memory/recall problem .Provide familiar items in room .<br><br>A review of Resident 57's care plan dated 4/26/24, indicated, .Psychosocial Well-Being .Actual or Potential Adjustment Impairment .Help [Resident 57] identify areas where they can maintain control .Provide privacy, personal objects .<br><br>A review of Resident 57's NURSE'S PROGRESS NOTES, dated 5/1/24, indicated, .Pt will move to bed B by the window .<br><br>During a concurrent observation and interview on 5/6/24, at 9:56 AM, in Resident 47 and Resident 57's room, a poster board above Resident 47's bed indicated, Happy Birthday [Resident 57]. A poster board above Resident 57's bed indicated, Happy Birthday [Resident 47]. Resident 47 stated the row of family photos displayed on the wall beside her bed did not belong to her, they belonged to her roommate.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/6/24, at 12:08 PM, Resident 47 stated she needed to adjust to the situation of her roommate's family pictures displayed around her. Resident 47 further stated, .I am getting tired of it .<br><br>During an interview on 5/7/24, at 8:55 AM, Resident 57 stated she was not sure why they had moved her and there was no space for her belongings.<br><br>During a concurrent observation and interview on 5/8/24, at 7:46 AM, Certified Nurse Assistant (CNA) 3 confirmed the items at Resident 47 and Resident 57 bedsides, which included the signs above their beds with their names, did not belong to them.<br><br>During an interview on 5/8/24, at 7:52 AM, Licensed Nurse (LN) 1 stated Resident 47 and Resident 57 switched beds on 5/2/24. LN 1 further stated it was important for residents to have their own belongings at their bedsides to provide them with familiar objects and make them feel at home. LN 1 stated there was the potential for Resident 47 and/or Resident 57 to be misidentified due to the signs over their beds which could lead to an error in the care they received.<br><br>During an interview on 5/9/24, at 2 PM, the Director of Nurses (DON) stated it was her expectation that the correct residents' belongings would be at their bedside. The DON further stated there was the potential for Resident 47 and Resident 57 to receive incorrect care if they were misidentified. The DON stated residents' rooms should provide a home-like environment which included having their own personal belongings.<br><br>A review of a facility policy and procedure titled, ENVIRONMENT OF CARE BUILDING AND SPACE CONSIDERATIONS, dated 3/20/24, indicated, .To provide guidelines for providing a safe, functional, supportive, and effective environment for patients .This is crucial in promoting healing and caring as well as facilitating quality patient care, achieving positive outcomes .Patients have the right to an environment that preserves dignity and contributes to a positive self-image .supports and maintains patient dignity and personhood . |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43071<br><br>Based on interview, and record review, the facility failed to provide a copy of written Notice of Transfer or Discharge of a facility-initiated transfer to the appropriate parties for one of one sampled resident (Resident 13), when Resident 13 or Resident 13's representative (RR) and the Long Term Care (LTC) Ombudsman (a patient rights advocate) were not notified in writing of Resident 13's transfer to the emergency room (ER) on 3/11/24.<br><br>This failure resulted in the State LTC Ombudsman not being informed of the resident's transfer, removed the opportunity for the State LTC Ombudsman to advocate on the resident's behalf, deprived the resident to be informed of resident rights regarding transfer/discharge, and had the potential for Resident 13 being inappropriately discharged .<br><br>Findings:<br><br>Review of Resident 13's SNF [Skilled Nursing Facility]/LTC Status Notification record dated 3/11/24, indicated Resident 13 was transferred to theER on [DATE] for intractable pain (a permanent severe pain condition) of left lower abdomen (stomach) and nausea.<br><br>Review of Resident 13's nurses progress note dated 3/11/24, indicated, .Asked resident if she want to be send out but refused x [times] 3 attempts until resident feel very severe pain .Sent out to ER .<br><br>Further review of Resident 13's record failed to show Resident 13 or Resident 13's representative was provided a notice of transfer in writing and that a copy of the notice was provided to the LTC Ombudsman.<br><br>During an interview on 5/8/24, at 12:33 PM, the Admission Coordinator (AC) stated they did not notify the LTC Ombudsman of residents' transfer to the ER when a return was expected.<br><br>During an interview on 5/8/24, at 1:51 PM, the AC stated a representative of the LTC Ombudsman informed her today that the facility was required to notify them of all discharges and transfers using a specific form. The AC stated they were not notifying the LTC Ombudsman of transfers with an expected return. The AC confirmed as per facility policy they should have notified the LTC Ombudsman of all discharges and transfers.<br><br>During a concurrent interview and record review on 5/8/24, at 3:10 PM, Medical Records (MR) verified Resident 13 and their RR was not provided a notice of transfer in writing.<br><br>During a concurrent interview and record review on 5/8/24, at 3:36 PM, MR verified the LTC Ombudsman was not notified of Resident 13's transfer to theER on [DATE].<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/8/24 at 5:07 PM, the Director of Nursing (DON) stated she did not think residents/RR were given notice of transfers in writing. The DON stated the LTC Ombudsman needed to be notified of all transfers because they were the residents' advocate, resource, and sometimes helped residents with decisions.<br><br>Review of a facility policy and procedure titled, DISCHARGE AND TRANSFER, revised 11/30/23, indicated, . TRANSFER TO ACUTE OR OTHER HEALTH CARE AGENCY .Inform resident, family or representative of transfer. provide a copy of Transfer Notice to resident, family or representative and one copy filed in the resident's medical record .Complete and fax Discharge/transfer Form to .Ombudsman . |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50161<br><br>Based on interview, and record review, the facility failed to develop baseline care plans for all of the identified problems noted on admission, within 48 hours of admission, to address resident-specific care needs for 3 of 18 sampled residents (Resident 309, Resident 310, and Resident 311), when Resident 309, Resident 310, and Resident 311's admission documentation indicated potential health care problem areas, but care plans were not developed for all of the identified problem areas within 48 hours of admission.<br><br>These failures resulted in Resident 309, Resident 310, and Resident 311 having the potential for bodily harm, injury, and had the potential for not providing effective and person-centered care for the residents.<br><br>Findings:<br><br>1. Review of Resident 309's Resident Face Sheet, indicated Resident 309 was admitted to the facility on [DATE].<br><br>Review of Resident 309's Admission Assessment Sheet, indicated Resident 309 had a speech impairment (slur), vision impairment, hearing impairment, falls in the past thirty days, unsteady gait (persons manner of walking), ambulation (ability to walk without the need for any kind of assistance) deficit (loss of), transfer deficit, weakness, and required assistive devices. In the section of the document titled, .Care Plan Needs Identified, the sections marked included .Hearing Impairment, Fall Risk, Chewing Difficulty, and Diabetic (a disease that affects how the body uses blood sugar) Management .<br><br>Review of Resident 309's undated Initial Care Plan, indicated that Resident 309 was hearing impaired and had a urinary foley catheter (a tube placed in the body to drain and collect urine from the bladder). In the section titled, Safety .History of falls: 3 falls in 45 days. In the section titled, Therapy Services .PT: Eval for RNA .Restorative functional goals: Program: PT Eval .Resident's functional goals .Improvement was marked or written out.<br><br>Review of Resident 309's Fall Risk Assessment, indicated that Resident 309 had a total score of twenty on 4/26/24. The Fall Risk Assessment indicated, .Instructions: Upon admission .If the score is 10 or greater, the resident should be considered at High Risk for potential falls. A prevention protocol should be initiated immediately and documented on the care plan .<br><br>During a concurrent interview and record review on 5/8/24, at 4:10 p.m., with the Minimum Data Set Coordinator (MDSC; MDS, an assessment tool), Resident 309's care plans and medical chart was reviewed. The MDSC stated the admitting nurse created the initial forty-eight-hour care plans from the information gathered on admission. The MDSC stated that care plans included a problem, a goal for the problem, and interventions to meet the goal.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 309's undated Initial Care Plan, the MDSC stated that was the only care plan document that was created for Resident 309 and was his forty-eight-hour care plan. The MDSC confirmed that Resident 309's undated Initial Care Plan, document contained identified problem areas, but no interventions or goals. The MDSC stated she was not sure why the document did not have interventions or goals listed for Resident 309, but the Initial Care Plan, document was used for all residents in the facility as their forty-eight-hour care plan. The MDSC stated the purpose of care plans would be for them to be individualized to the resident and to help with instructions for staff on providing care to residents.<br><br>During a concurrent record review and interview on 5/8/24, at 4:52 p.m., with the Administrative Director of Post-Acute Services (AD), Resident 309's care plans and medical chart was reviewed. The AD stated care plans should contain three components which included the problem, interventions, and goals. The AD stated it was her expectation that staff would create a 48-hour baseline care plan for Resident 309 by 4/28/24 since he was admitted on [DATE]. The AD confirmed that Resident 309's chart included a diagnosis of urinary catheter, history of falls, monitor for hydration, diabetes, hypertension, and pain. The AD stated that care plans should be created on admission regarding current diagnosis and/or the problem list. The AD reviewed Resident 309's undated Initial Care Plan, to check and confirm if all components of a care plan were contained within the document. The AD confirmed that this document did not contain all components of a care plan and her expectation would be that it would contain all three areas. The AD confirmed that Resident 309 did not have a completed baseline care plan in his chart within forty-eight hours of admission based off of Resident 309's diagnosis listed in the medical record. The AD confirmed that Resident 309 had a care plan for falls dated 5/1/24 at 2:30 p.m. which was created for Resident 309 after he had a fall in the dining hall. The AD confirmed that Resident 309's Fall Risk Assessment, was completed on his admitted [DATE]. The AD confirmed that Resident 309's fall risk score was a twenty and this placed Resident 309 at high risks for falls. The AD confirmed that due to Resident 309's history of falls, history of strokes and the Fall Risk Assessment, score, Resident 309 should have had a care plan for falls created within 48 hours of admittance. The AD stated this could have prevented Resident 309's fall if measures were in place to address Resident 309's high fall risk. The AD stated the value of a care plan was for communication between staff and safety for the resident.<br><br>2. During a review of Resident 310's Resident Face Sheet, indicated Resident 310 was admitted to the facility on [DATE].<br><br>During a review of Resident 310's Physician Order Report, indicated that Resident 310 had an admitting diagnosis which included but not limited to cerebral infarction due to embolism unspecified (blood supply to the brain is blocked or reduced and prevents brain tissue from getting oxygen and nutrients), and unspecified symptoms and signs involving the musculoskeletal system.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 5/8/24, at 5:36 p.m., with AD, Resident 310's care plans and medical chart was reviewed. The AD confirmed that Resident 310 was admitted on [DATE]. The AD confirmed that the only care plan that was created for Resident 310 upon admission was the .Psychotropic Med [medication] Care Plan The AD confirmed Resident 310 was admitted with diagnosis that included GERD (stomach acid repeatedly flows back into the tube connecting your mouth and stomach), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high, hyperlipidemia (an excess of fats in your blood) , and CVA (stroke; occurs when a blood clot blocks or plugs an artery (blood vessel) leading to the brain). The AD confirmed that a fall risk assessment was completed on 5/1/24, which was fourteen days after Resident 310's admission to the facility. The AD confirmed that there should have been care plans in place within forty-eight hours of Resident 310's admission based off the mentioned diagnosis, and this was not done. The AD stated her expectation from staff would be that Resident 310 would have had a care plan addressing falls and diabetes within 48 hours of admission to the facility.<br><br>3. During a review of Resident 311's Physician Order Report, indicated that Resident 311 was admitted into the facility on [DATE]. Resident 311 had an admitting diagnosis which included but not limited to diastolic (congestive) heart failure (a condition in which your heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly), acute respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues in your body), urinary tract infection (infection in any part of the urinary system), and pain.<br><br>Review of Resident 311's Initial Care Plan, dated 2/24/24 [sic], indicated that Resident 311 had a urinary foley catheter (a tube placed in the body to drain and collect urine from the bladder). In the section titled Safety .History of falls: 1-2 falls in past 30 days . was noted.<br><br>Review of Resident 311's Fall Risk Assessment indicated that Resident 311 had a total score of fourteen on 4/16/24. Resident 311's 4/16/24 Fall Risk Assessment indicated, .Instructions: Upon admission If the score is 10 or greater, the resident should be considered at High Risk for potential falls. A prevention protocol should be initiated immediately and documented on the care plan .<br><br>During a concurrent interview and record review on 5/8/24 at 5:18 p.m. with the AD, Resident 311's care plans and medical chart was reviewed. The AD confirmed that Resident 311 was admitted on [DATE]. The AD confirmed that Resident 311's Fall Risk Assessment was completed on his admitted [DATE]. The AD confirmed that Resident 311's fall risk score was a fourteen and this placed Resident 311 at high risks for falls. The AD verified that Resident 311 had a psychosocial care plan and discharge care plan within 48 hours of admittance. The AD confirmed that Resident 311's Initial Care Plan, dated 2/24/24 [sic], did not contain all the components of a care plan. The AD confirmed that a care plan should have the identified problem, interventions, and goals and the Initial Care Plan created for Resident 311 only contained the problems. The AD confirmed that there were no care plans created within forty-eight hours of Resident 311's admittance to the facility to address Resident 311's high risk for falls, his identified foley catheter, and other pertinent diagnosis.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a facility policy and procedure titled, FACILITY PROCEDURE: CARE PLANS / RAI revised 5/24/23, indicated, .[Facility name] Definitions: Care Plans-will identify problems, include short and long term goals with realistic, measurable and time limited objectives. It will describe resident specific interventions / approaches with disciplines responsible identified .A nursing care plan will be initiated by the RN at the time of admission, and will be added to by the appropriate disciplines as full assessment is complete .A Base Line Care Plan must be developed and implemented by the IDT [inter-disciplinary team] within 48 hours of a resident's admission . |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50161<br><br>Based on interview, observation, and record review, the facility failed to ensure residents had access to their bilateral hearing aids and failed to assist in locating and/or arranging for audiologist (ear doctor) referral consult services for two of two sampled residents (Resident 311 and Resident 309) when:<br><br>1. A Certified Nursing Assistant (CNA) asked Resident 311's wife to take Resident 311's hearing aids home; and,<br><br>2. The facility did not assist or refer for follow-up auditory services for Resident 309 to obtain hearing aids.<br><br>These failures had the potential to impede Resident 311's and Resident 309's maintaining and/or achieving independent functioning, dignity, and well-being due to not being able to hear adequately during a conversation.<br><br>Findings:<br><br>1. Review of Resident 311's Initial Care Plan, dated 2/24/24 [sic], indicated, .Initial information .Hearing . Hearing adequate .Hearing impaired . was marked.<br><br>Review of Resident 311's undated Resident Belongings Sheet, indicated that Resident 311 had a right and left hearing aid. The document included a handwritten note in the hearing aid section that stated .R/L [right and left] red & blue BRANDNAME [NAME]-WIFE BROUGHT IT HOME 4/24 .<br><br>During a concurrent interview and observation on 5/7/24, at 1:41 p.m., with Resident 311 it was observed that Resident 311 was sitting in a wheelchair and was leaning forward when his wife was speaking to him. When asked if Resident 309 was hard of hearing Resident 309 stated he was and stated he wears hearing aids in both ears.<br><br>During an interview on 5/7/24, at 1:41p.m., with Family Member (FM) 2, FM 2 stated that Resident 311 was hard of hearing and wears hearing aids in both ears. FM 2 stated that up until Resident 311 got sick a few weeks ago he wore them every day and that hearing aids helped Resident 311 to hear better. FM 2 stated that when Resident 311 was admitted to the facility staff were aware that Resident 311 wore hearing aids. FM 2 stated that Resident 311 needed to get them adjusted and that she needed help from the facility with that. FM 2 stated that a couple of week ago a staff member told her that Resident 311 did not want to wear his hearing aids and told FM 2 to take them home. FM 2 stated she did take them home and Resident 311 has not worn them since and is not able to hear very well.<br><br>During an interview on 5/8/24 at 10:14 a.m., CNA 4 stated that Resident 311 was hard of hearing and had hearing aids but that he did not like to wear them. CNA 4 stated that the hearing aids were kept in the top drawer next to his bed. CNA 4 stated that during his first week at the facility, Resident 311 did not like to wear his hearing aids. CNA 4 stated that FM 2 asked her why Resident 311 was not wearing his hearing aids and CNA 4 told FM 4 that Resident 311 did not want to wear them and told FM 2 that she could take them home.<br><br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/8/24, at 10:44 a.m., with License Nurse (LN) 8, LN 8 stated she was not aware that Resident 311 had hearing issues or needed hearing aids. LN 8 stated that the CNA was responsible for placing and assisting residents with their hearing aids. LN 8 stated she was not sure if she would send a resident's hearing aids home because families usually wanted the resident to wear them while in the facility.<br><br>During an interview on 5/09/24, at 12:55 p.m., Resident 311 stated that he would wear his hearing aids if he had them.<br><br>During an interview on 5/9/24, at 12:55 p.m., with FM 2, FM 2 stated that Resident 311 had hearing aids on the list of belongings when Resident 311 was admitted to the facility. FM 2 stated that when Resident 311 wears his hearing aids he can hear better and was able to communicate more. FM 2 stated she would like Resident 311 to wear his hearing aids.<br><br>During an interview on 5/9/24 at 1:10 p.m., CNA 4 stated that she did not let a LN know that Resident 311 was not wearing his hearing aids and stated she did not inform a LN that she sent Resident 311's hearing aids home with his wife.<br><br>2. Review of Resident 309's Admission Assessment Sheet, dated .indicated Resident 309 was hearing impaired.<br><br>Review of Resident 309's undated Initial Care Plan, indicated that resident was hearing impaired. The Initial Care Plan did not list interventions or goals regarding Resident 309's hearing impairment.<br><br>During an interview on 5/9/24, at 1:14 p.m., with Licensed Nurse (LN) 8, LN 8 stated that she was aware that Resident 309 was hard of hearing she but did not notify other staff regarding his hearing impairment.<br><br>During a concurrent interview and observation on 5/7/24, at 9:09 a.m., Resident 309 was observed sitting on a chair next to his bed wearing glasses. Resident 309 stated he was hard of hearing and had previously worn hearing aids. Resident 309 stated he had not had his hearing aids for a while and needed new hearing aids. Resident 309 said his last set were stolen when he was at another facility.<br><br>During a concurrent interview on 5/8/24, at 10:21 a.m., with Family Member (FM) 1, FM 1 stated Resident 309 had worn hearing aids in both ears and it has been a long time since he had them. FM 1, in regards to Resident 309, stated, he definitely needs hearing aids. FM 1 stated facility staff said they were going to help get Resident 309 with obtaining new hearing aids when Resident 1 was first admitted .<br><br>During an interview on 5/8/24, at 10:25 a.m., CNA 4 stated that she was not aware of Resident 311 being hard of hearing or wearing hearing aids.<br><br>During a concurrent interview and observation on 5/9/24, 1:03 p.m., Resident 309 stated the facility had not spoken to him regarding his hearing aids. Resident 309 stated, I cannot hear, and it makes me feel dumb and like an idiot. Resident 309 stated that when he first was admitted to the facility, facility staff stated they would help him get new hearing aids.<br><br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/9/24, at 4:21 p.m., with the Director of Nursing (DON), the DON stated that at admission if the facility was aware that a resident was hard of hearing or wore hearing aids than a 48 initial care plan would be created. The DON stated that the care plan would include interventions and goals. The DON stated the care plan would include future follow-up and/or appointments needed to be scheduled for the resident to address the resident's hearing problem. The DON stated that if it was identified that a resident had hearing aids, or it comes to staff's attention that a resident is hard of hearing then staff need to share this information with the charge nurse so it can be addressed and care planned. The DON stated that if a resident had hearing aids and does not want to wear them, the CNA should let the charge nurse (CN) know so it can be addressed. The DON stated it was her expectation that the CNA would not send hearing aids home and the protocol would be for the CNA to bring the issue of the resident not wanting to wear their hearing aids to the attention of the CN so the CN could address the reason the resident does not want to wear their hearing aids. The DON stated that if this was not done it could cause a delay in proper care for the resident. The DON stated that the resident's communication ability, overall socialization, and dignity could be negatively affected and place the resident at risk for injury if they could not adequately hear. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50161<br><br>Based on interview, and record review, the facility failed to provide restorative services (activities to assist residents with maintaining or improving physical function) for one of twenty residents (Resident 310) referred to the RNA program (Restorative Nursing Aide; administers restorative services) when, a recommendation for RNA services was written for Resident 310 on 4/23/24 by the Physical Therapy (PT) Department, but was not relayed to the skilled nursing facility to initiate.<br><br>This failure resulted in the potential for Resident 310 for not attaining and maintaining their highest possible level of physical and functional well-being.<br><br>Findings:<br><br>Review of Resident 310's Resident Face Sheet, indicated Resident 310 was admitted to the facility on [DATE].<br><br>Review of Resident 310's Physician Order Report, indicated that Resident 310 had an admitting diagnosis which included but not limited to cerebral infarction due to embolism unspecified (blood supply to the brain is blocked or reduced and prevents brain tissue from getting oxygen and nutrients), and unspecified symptoms and signs involving the musculoskeletal system. The report indicated that on 4/18/24 an order was placed by Medical Director (MD) 1 for Rehabilitation Therapy: Rehab Potential: Fair .PT (Physical Therapy) Referral and Treatment .<br><br>During an interview on 5/6/24, at 10:09 a.m., Resident 310 stated, I was offered physical therapy but have yet to see it. Resident 310 stated he has been waiting since he arrived at the facility and was supposed to get physical therapy. Resident 310 stated that he was very interested in receiving physical therapy since having a stroke.<br><br>During an interview and observation on 5/6/24, at 1:42 p.m., Resident 310 stated that he was assessed a week ago but was still waiting for PT and was feeling frustrated. Resident 310 stated that Restorative Nursing Assistant (RNA) 1 told him that they were still waiting for physical therapy documents regarding the treatment plan.<br><br>During an interview and observation on 5/7/24, at 2:04 p.m., Resident 310 stated that he needs rehabilitation, and he has asked staff repeatedly about it.<br><br>During an interview on 5/8/24 at 11:08 a.m., with Licensed Nurse (LN) 8, LN 8 stated that she was not sure if Resident 310 had physical therapy orders but had seen Restorative Nursing Assistant (RNA) 1 walking Resident 310.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 5/8/24 at 2:50 p.m., with RNA 1, RNA 1 stated no paperwork or recommendations had been received for RNA services for Resident 310. RNA 1 stated she had been trying to work with Resident 310 by walking him and providing stretch exercise's but technically could not add Resident 310 to the RNA program because Resident 310 was not referred for the RNA program yet by PT. RNA 1 reviewed the RNA binder (which contained resident specific PT/OT recommendations, exercises, and daily documentation of RNA completion for all residents receiving RNA services) and confirmed there was no PT referral in the RNA binder for Resident 310. RNA 1 stated a referral would include a form that indicated the type of exercises and repetitions (number of times to complete each exercise) for the resident to do along with instructions for her that included pictures of the exercises for a resident to complete.<br><br>During a concurrent interview and record review on 5/8/24, at 3:13 p.m., with the Physical Therapist Lead (PTL) on a phone call and with the Administrative Director of Post-Acute Services (AD) who was present in room. The PTL stated that both physical and occupational therapy assessments were completed for Resident 310 and Resident 310 was discharged back to nursing care. The PTL stated the PT recommendation and referral was for the RNA to work with Resident 310. The AD and the PTL confirmed Resident 310's PT assessment and RNA referral was completed on 4/23/24. The AD reviewed the RNA binder and confirmed that there was no referral or documentation for Resident 310 in the RNA binder. The PTL stated that the RNA binder should include PT orders and referrals for Resident 310. The PTL stated she did not know why Resident 310 did not have the PT referral in RNA binder. The PTL was not aware that Resident 310 was not currently working with the RNA. The PTL stated that the PT orders and RNA referral must not have been transmitted by the PT department and she was not aware Resident 310 was not receiving RNA services. The PTL stated it was her understanding that once the referral was made by PT that RNA services would start as soon as possible. The PTL stated that RNA services helped to maintain function and independence for residents.<br><br>During an interview and record review on 5/8/24, at 3:40 p.m., the AD stated her expectation would be for PT to hand off to the RNA so that the PT could answer questions and provide instructions for exercises required for the resident.<br><br>Review of Resident 310's Physical Therapy and Initial Evaluation, that was completed on 4/23/24, indicated under assessment, .Recommend referral to RA [restorative aide] to assist with supervised amb [ambulation (walking)] and exercise program to maintain function .Referral .referral to RA to maintain functional mobility and strengthen as able-recommend supervised<br><br>Review of a facility policy and procedure titled, FACILITY PROCEDURE: FUNCTIONAL MANAGEMENT CARE POLICY, dated 10/1/20, indicated, .[Facility name] Skilled Nursing Units shall provide .restorative care to meet each resident's individual needs as required in each resident's plan of care .residents will receive care that enables them to achieve and/or maintain their highest practicable level of physical independence and provide a continuity of care .Functional Management (FM) primary focus is to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident and shall be directed to prevent deterioration .Therapies, Physical .Performs Therapy Evaluations and Treatments as ordered by physician .Works with Charge Nurse regarding appropriate FM goals and programs individualized for the resident, and trains CNA's [certified nursing assistance] if needed .Serve as educational resources. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>43071<br><br>Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided to prevent accident hazards for 12 of 60 residents (Resident 2, Resident 20, Resident 21, Resident 30, Resident 34, Resident 40, Resident 41, Resident 44, Resident 50, Resident 54, Resident 55, Resident 56, and Resident 309), when:<br><br>1. Resident 20 and Resident 40's wander guard (a bracelet that triggers alarms when resident attempts to leave the facility unattended) were not monitored for functioning,<br><br>2. Wander guard system (a device/sensor that trigger alarms if a wander guard wearer approaches near it) was not working at the front gate in Unit 7,<br><br>3. Wander guard system was not checked monthly for functioning; and,<br><br>4. Staff was not present during lunch on 5/7/24 in the dining room in Unit 7.<br><br>These failures had the potential for Resident 20, Resident 40, Resident 41, Resident 50, and Resident 55 for elopement (running away/wandering off without staff knowledge that poses serious safety risk), accidents, injury, and had the potential for Resident 2, Resident 21, Resident 30, Resident 34, Resident 44, Resident 54, Resident 56, and Resident 309 in the dining of choking and safety risk.<br><br>Findings:<br><br>1a. Review of Admission Record indicated Resident 20 was admitted to the facility with multiple diagnoses including but not limited to dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with behavioral disturbance, mood disorder, and depressive disorder.<br><br>Review of Resident 20's care plan dated 7/31/20, indicated, Problem .[Resident 20] with WANDERING BEHAVIOR] HX [History of] attempts to leave facility unattended. Elopement attempts. Impaired safety awareness; potential injury .Approach .Provide wander alarm (placed in wheelchair) .<br><br>During an interview on 5/8/24, at 10:09 AM, Licensed Nurse (LN) 7 stated Resident 20 had a behavior of wanting to go home and was at risk of elopement. LN 7 further stated Resident 20 would go to the front gate and would try to get out. LN 7 stated Resident 20 was able to propel herself in the wheelchair. LN 7 further stated Resident 20 had a wander guard and the front gate would keep her from eloping.<br><br>During an observation on 5/8/24, at 10:39 AM, a wander guard was observed on Resident 20's wheelchair.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/8/24, at 10:45 AM, the MDS (Minimum Data Set nurse who collects and assesses information for the health and well-being of residents in nursing homes) stated Resident 20 was at risk of elopement. The MDS stated Resident 20 would try to get out and had attempted a couple of times. The MDS stated Resident 20 had a wander guard. The MDS stated they checked the alarms periodically for functioning and did not keep a log of it.<br><br>During an interview on 5/8/24, at 11:01 AM, LN 7 stated they were not monitoring residents' wander guards for functioning to her knowledge.<br><br>During a concurrent interview and record review on 5/8/24, at 4:17 PM, LN 8 stated wander guards were used for residents with elopement behaviors. LN 8 stated Resident 20 was at risk of eloping. LN 8 added Resident 8 would open the door. LN 8 stated wander guards should be checked for functioning and placement every shift to make sure it was working. Resident 8's Treatment Administration Record (TAR) was reviewed with LN 8. LN 8 verified the record only indicated Resident 20 had a wander guard for safety and did not indicate to check the wander guard for functioning, placement and the frequency of how often the wander guard needed to be checked. LN 8 verified there was no record indicating Resident 20's wander guard was checked for functioning and placement.<br><br>During a concurrent interview and record review on 5/8/24, at 5:15 PM, the Director of Nursing (DON) stated wander guards should be checked for functioning as per physician order, she believed it was monthly. The DON stated it should be on the TAR. The DON stated she did not believe they checked resident wander guards for placement. The DON stated it would be team effort to check wander guard placement. The DON added licensed nurses would check wander guard placement during the residents' skin check. Resident 20's TAR was reviewed with the DON. The DON verified there was no record of Resident 20's wander guard monitoring. The DON stated she did not understand why there was not an order for Resident 20's wander guard monitoring.<br><br>1b. A review of Resident 40's Resident Face Sheet, indicated she was admitted to the facility in 2022 with diagnoses which included unspecified dementia.<br><br>A review of Resident 40's care plan dated 4/1/24, indicated, Problem .[Resident 40] has wandering behavior r/t [related to] confusion d/t [due to] dementia .Elopement risk .Impaired safety awareness; potential injury . Goal .will wander safely within specified boundaries .will not leave facility unattended .Approach .Provide wander alarm .<br><br>During an interview on 5/7/24, at 9:03 AM, LN 5 stated Resident 40 wore a wander guard alarm on her left leg to prevent elopement from the facility. LN 5 stated the wander guard battery was checked weekly by licensed staff to ensure functioning.<br><br>During an interview on 5/9/24, at 1:28 PM, LN 4 stated Resident 40 attempted to leave the building every time a door opened. LN 4 further stated the facility added another gate last year due to Resident 40's elopement from the facility.<br><br>A review of Resident 40's Treatments Flowsheet, dated 5/1-5/31/24 indicated, .Wander Guard for safety Once a Day on Wed [Wednesday] Check Battery weekly . The space provided for staff to initial the battery check for the date of 5/8/2024 was blank.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 5/9/24, at 7:32 AM, the Infection Preventionist (IP) confirmed there was no documentation to indicate Resident 40's wander guard battery had been checked on 5/8/24.<br><br>During an interview on 5/9/24, at 1:43 PM, LN 1 stated it was important to check Resident 40's wander guard battery weekly due to the potential of the battery to randomly stop working. LN 1 further stated if the wander guard was not working Resident 40 could elope from the facility. LN 1 stated if Resident 40 eloped from the facility there was the potential for her to be hit by a car, suffer a fall, or become lost.<br><br>During a concurrent interview and record review on 5/8/24, at 1:40 PM, the Practice Administrator (PA) stated nursing staff checked residents' wander guards weekly for proper functioning. The PA further stated the weekly check should be documented on the Resident's treatment flowsheet. The PA stated the purpose of monitoring for placement and functioning weekly was to ensure the system was working and operational for the safety of the residents who were high wander/elopement risks. The PA verified the facility policy indicated alarms to be checked for activation/functioning periodically every shift. The PA stated alarm in the policy meant wander guard on resident. The PA stated their policy was conflicting. The PA further stated they checked wander guards every week. The PA stated per policy residents' wander guard should be checked every shift for functioning. The PA confirmed they were not following their current policy for monitoring resident's wander guard every shift.<br><br>During a concurrent interview and record review on 5/9/2024, at 2:04 PM, the DON confirmed there was no documentation to indicate Resident 40's wander guard battery was checked on 5/8/24. The DON further stated if the wander guard battery was not checked there was the potential risk for Resident 40 to elope from the facility.<br><br>A review of a facility policy titled, WANDER, revised 5/24/23, indicated, .Provide a safe environment for residents .Any resident observed to exhibit behavior or symptoms of potential elopement or wandering will be assessed for cause and patterns .Doors and exits accessible to residents are alarmed, gated or both . Resident Assessment Coordinator will monitor the care plans of residents assessed to be at risk. Alarms will be periodically checked for activation by staff on each shift .<br><br>2. During a concurrent observation and interview on 5/8/24, at 11:01 AM, LN 7 took Resident 20 near the wander guard system at the front gate in unit 7 to check if it was working. The Wander guard system did not trigger an alarm. LN 7 stated someone might have silenced the monitor. LN 7 turned the silence mode off on the monitor by the nurses' station. LN 7 took Resident 20 again near wander guard system at the front gate. The wander guard system did not trigger an alarm. Housekeeper (HK) standing near the nurses' station stated, That's odd. It didn't go off. LN 7 tested the wander guard system at the front gate for functioning with a brand-new unused wander guard. The wander guard system did not trigger an alarm. LN 7 stated she tested the wander guard system with two wander guards. LN 7 stated it must be the wander guard system at the front gate that was not working. LN 7 stated there was no one in-charge of checking the wander guard system to ensure it was working.<br><br>During an interview on 5/8/24, at 1:40 PM, the PA stated wander guard systems were checked monthly for proper functioning. The PA stated wander guard systems should be checked for functioning to protect confused, in-cognitively residents' from wandering to unsafe areas. The PA stated if wander guard system was not working then residents with wandering behavior were at risk of elopement and injury.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of undated and untitled facility provided list of residents with wander guards indicated Resident 20, Resident 41, Resident 50, and Resident 55 had a wander guard in unit 7.<br><br>3. During an interview on 5/8/24, at 11:11 AM, Plant Maintenance (PM) 2 stated he checked the wander guard system once a month.<br><br>During an interview on 5/8/24, at 3:45 PM, Director of Plant Maintenance (DPM) stated they oversaw the wander guard alarm system. The DPM stated they checked the wander guard system monthly for maintenance and functioning. The DPM stated they did not have a policy on the wander guard system.<br><br>Review of untitled facility document dated 4/1/24, indicated, .Facility Inspections .Facility Ensure wonder[sic] guard system is functioning properly .Schedule .Monthly .Wonder[sic] Guard System Inspection .Activity Log . Completed .At 4/3/2024 .<br><br>During concurrent interview and record review on 5/8/24, at 5:15 PM, the DON verified the wander guard system was last checked for functioning on 4/3/24. The DON stated it should be done within a month. The DON stated the wander guard system should have been inspected for functioning by 5/3/24. The DON stated when the wander guard system was not checked within the month, it delayed ensuring proper functioning of the wander guard system and posed elopement and safety risk for residents. The DON acknowledged a month was a long period to check the wander guard system for functionality. The DON stated a lot could happen, could pose safety risk if the wander guard system stopped working/dysfunction in between month period.<br><br>4. During an observation on 5/7/24, at 1:05 PM, Resident 2, Resident 21, Resident 30, Resident 34, Resident 44, Resident 54, Resident 56, and Resident 309 were eating lunch in the dining room in unit 7. There was no staff member present in the dining room.<br><br>During continued observation on 5/7/24, at 1:14 PM, Resident 309's urinary catheter bag (a drainage bag attached to a catheter (tube) that is inside the bladder to collect urine) was hanging on Resident 30's walker who was sitting next to him. Resident 309's walker was behind his chair about 2-3 feet away. Resident 309 finished his meal and started to leave the dining room using his walker while his urinary bag was hanging on Resident 30's walker.<br><br>During continued observation on 5/7/24, at 1:16 PM, Licensed Nurse (LN) 7 walked into the dining room. LN 7 grabbed Resident 309's urinary bag from Resident 30's walker and hanged on Resident 309's walker.<br><br>During an interview on 5/7/24, at 1:18 PM, LN 7 confirmed Resident 309's urinary bag was hanging on Resident 30's walker. LN 7 stated Resident 309 might have hanged his urinary bag on Resident 30's walker. LN 7 stated she did not see Resident 309 doing it because she was not present in the dining room. LN 7 stated there was no staff member present in the dining room. LN 7 stated a staff member would be present in the dining room only if a resident needed assistance with feeding or was at choking hazard. LN 7 stated residents in the dining were alert and able to feed themselves.<br><br>(continued on next page) |

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| Adventist Health Sonora - D/P Snf | 179 South Fairview Lane<br>Sonora, CA 95370 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/8/24, at 4:55 PM, the DON stated staff should be present in the dining room after food was served for supervision, in case of choking, and to meet residents' needs. The DON stated she heard that Resident 309's urinary bag was hanging at Resident 30's walker. The DON stated Resident 309 would get confused about his urinary bag and might have hanged his urinary bag at Resident 30's walker. The DON stated staff presence in the dining room would have absolutely prevent it from happening. The DON stated her expectation was staff to be present in the dining room since they had confused residents.<br><br>47369 |

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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>50161<br><br>Based on interview, observation, and record review, the facility failed to ensure respiratory care was provided in accordance with professional standards of practice for two of two sampled residents (Resident 311 and Resident 48) when:<br><br>1. There was no oxygen safety signage posted outside Resident 311's room; and,<br><br>2. Oxygen tubing was not labeled and was not changed out within seven days for Resident 48 and Resident 311's oxygen tubing was not labeled.<br><br>These deficient practices had the potential for Resident 48 and Resident 311 to have complications related to improper treatment while receiving oxygen therapy.<br><br>Findings:<br><br>1. During a review of Resident 311's Physician Order Report, indicated that Resident 311 had an admitting diagnosis which included acute respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues in your body).<br><br>During an interview and observation on 5/6/24, at 10:05 a.m., Resident 311 was observed in his room sitting in a wheelchair next to his bed and was receiving oxygen at one point five liters per minute (LPM) via nasal canula (a nasal cannula is a device that delivers extra oxygen through a tube inserted into your nostrils).<br><br>During a concurrent interview and observation on 5/6/24, at 10:56 a.m., with Licensed Nurse (LN) 8, LN 8 stated that Resident 311 was placed on oxygen this last Saturday. LN 8 confirmed that there was no oxygen in use signage posted outside of Resident 311's room. LN 8 stated the risk to the resident could be injury since oxygen was combustible (the process where a substance burns in the presence of oxygen, giving off heat and light in the process).<br><br>During an interview on 5/9/24, at 4:21 p.m., with the Director of Nursing (DON), the DON stated that if a resident had orders for oxygen, then her expectation would be that an oxygen warning signage would be posted outside the residents' room. The DON stated the risk to not having the oxygen warning signage posted could result in injury and/or explosion.<br><br>2a. During a review of Resident 311's Physician Order Report, indicated that Resident 311 had an admitting diagnosis which included but not limited to diastolic (congestive) heart failure (a condition in which your heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly), and acute respiratory failure with hypoxia.<br><br>During an interview and observation on 5/6/24, at 10:05 a.m., Resident 311 was observed in his room sitting in a wheelchair next his bed and was receiving oxygen at 1.5 LPM via nasal canula. It was observed the oxygen tubing had no label with a date indicating when it was first applied for Resident 311.<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 | During a concurrent interview and observation on 5/6/24, at 10:56 a.m., with LN 8, LN 8 stated that Resident 311 was placed on oxygen this last Saturday (5/4/24) and confirmed that Resident 311's oxygen tubing was not labeled with a date of when it was first applied to Resident 311. LN 8 stated that oxygen tubing was changed once a week on Sunday evenings. LV 8 stated the oxygen tubing should be labeled with the date of when it was first applied for resident use and oxygen tubing was changed once a week for cleanliness and to prevent infection to resident.<br><br>During a concurrent interview and observation on 5/7/24, at 9:38 a.m., with the Infection Preventionist (IP), the IP was observed writing the tubing date on Resident 311's oxygen tubing. The IP confirmed Resident 311 did not have his tubing labeled with a date of application. The IP stated she likes to write the date directly on the tubing itself and not on the bag the tubing rests in because the bag could be changed and redated and tubing could still be outdated. The IP stated the oxygen tubing was changed every seven days. The IP stated there could be a buildup of bacteria in the tubing when the tubing was not changed out every seven days.<br><br>2b. During a review of Resident 48's Physician Order Report, indicated that Resident 48 had an admitting diagnosis which included but not limited to shortness of breath.<br><br>During an observation on 5/6/24, at 10:31 a.m., Resident 48 was observed sleeping in his bed. Resident 48 was receiving oxygen at 2.5 LPM via nasal canula. It was observed the oxygen tubing was not dated to indicate when it was first used for Resident 48 and the tubing was partially laying on the floor next to the bed.<br><br>During a concurrent observation and interview on 5/6/24, at 11 a.m., the Lead Charge Nurse (CN) 1 confirmed that Resident 48 was receiving oxygen via a nasal canula, the tubing was on the floor, and the tubing was not dated. CN 1 stated that a date of 4/28/24 was handwritten on the bag containing some of the tubing. CN 1 stated that the tubing was nine days old if she goes off the date written on the bag. CN 1 stated that the oxygen tubing should be changed every seven days and confirmed the tubing was outdated.<br><br>During an interview on 5/9/24, at 1:08 p.m., with the IP and the Infection Prevention and Quality Director (ID), the IP stated that the tubing should be changed once a week or every seven days to prevent infection. The IP stated that the tubing should be changed immediately if the tubing touches the floor. The IP stated that if the tubing was not changed every seven days or if it touches the floor, then it would place the resident at risk for infection.<br><br>During an interview on 5/9/24, at 4:21 p.m., with the Director of Nursing (DON), the DON stated that if a resident had orders for oxygen, then her expectation for staff would be that the oxygen orders were followed, and that the oxygen tubing was labeled with the start date of the tubing application. The DON stated that the risk to the resident if the tubing was not labeled would be that it could be used longer then the seven days. The DON stated that if the oxygen tubing was older than seven days the risk to the resident could be infection. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>40903<br><br>Based on observation and interview, the facility failed to ensure safe medication monitoring practices for a census of 60 when:<br><br>1. Vital Signs (or VS, markers such as heartbeat or Heart Rate [HR] and Blood Pressure [or BP, the pressure of blood flow into the arteries]) hold parameters (conditions in which nursing staff to hold the medication and/or call the doctor) were not ordered for cardiac (heart) and blood pressure medications for safe monitoring for Resident 28, Resident 11, and Resident 2; and,<br><br>2. Resident 28's high risk (drug with risk of adverse effects even with appropriate dose and indication) blood thinner medication, called Apixaban (or Eliquis, used to treat or prevent blood clot and can cause bleeding) did not have monitoring parameters in the Medication Administration Record (or MAR, a document that listed drugs administered and the daily nursing monitoring at the point of drug administration) to assess or prevent the risk of bleeding.<br><br>These failures could contribute to unsafe monitoring and medication use.<br><br>Findings:<br><br>1a. During a review of Resident 28's MAR, dated 5/2024, the MAR indicated the following medications that could affect Resident 28's Heart Rate (HR) and Blood Pressure (BP):<br><br>-Carvedilol (or Coreg, a drug belongs to a class drugs known as beta blockers, that slows down the heart rate and blood pressure) ordered to be given as twice daily.<br><br>-Spironolactone (or Aldactone, used to lower the blood pressure) ordered to be given once a day.<br><br>-Furosemide (or Lasix, also known as water pill, drug used to treat edema, water retention in the body, could affect blood pressure)<br><br>Further review of the MAR indicated an order to only check blood pressure once a week on Monday's. The MAR did not have a slot to document recorded BP, pulse, or the HR when measured.<br><br>During an interview with Licensed Nurse (LN) 1, on 5/9/24, at 8:04 AM, LN 1 stated the nurses used a guideline sheet posted on a binder at the nursing station to guide them for usual normal limits on HR, BP, and other vital signs.<br><br>Review of an undated guideline sheet titled, Vital sign (V.S.)- Normal Limits, in a binder at the nurse station at unit 6, the sheet indicated the normal HR as Heart Rate: 60-90 beats per minutes (BPM) and the normal BP as Blood Pressure: Systolic (SBP):90-150 mm/Hg; Diastolic (DBP):60-80 mm/Hg (Blood Pressure is measured in units of millimeters of mercury (mmHg);The readings given in pairs, with the upper [systolic] value first, followed by the lower [diastolic] value).<br><br>Review of the Resident 28's medical record titled, Weight and Vital Sign record, with a date range of 1/1/23 to 3/24/24, the record posted the Heart Rate (HR) below 60 as follows:<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2/19/24: HR= 58,<br><br>12/1/23: HR= 58,<br><br>11/1/23: HR= 50,<br><br>9/1/23: HR= 58,<br><br>4/1/23: HR= 50.<br><br>Further review of the record indicated the vital signs were documented once a month during January 2023 to February of 2024.<br><br>1b. During a review of Resident 11's medical record titled, Physician Order Report, dated 5/2024, the record indicated a medication order for metoprolol (or Lopressor, drug used to treat BP and lower the heart rate) to be given twice a day since 9/5/23 with no hold parameters to monitor the vital signs. Further review of the record indicated an order dated 8/3/22 to check vital sign once a month with no instruction on how to address the measurement.<br><br>Review of Resident 11's medical record titled, Weight and Vital Sign Record, with a date range of 2/26/24 to 5/1/24, the record indicated the Heart Rate (HR) below 60 as follows:<br><br>2/26/24: HR= 59,<br><br>3/4/24: HR= 58,<br><br>3/6/24: HR= 53,<br><br>3/22/24: HR= 57,<br><br>4/11/24: HR= 54.<br><br>The record did not show any documentation of nursing intervention under action column of the record.<br><br>1c. During a review of Resident 2's medical record titled, Physician Order Report, dated 5/2024, the record indicated two medication orders for Valsartan (or Diovan, used to treat BP and heart failure) to be given once a day since 11/10/23 and hydrochlorothiazide (or HCTZ, or water pill used to treat BP and used as diuretic) to be given once a day since 7/10/23 for diagnosis of Essential Hypertension (or high blood pressure). Further review of the record did not show any parameters to monitor the medications. The record did not show any order to measure the vital signs or BP on a regular basis.<br><br>During a review of Resident 2's MAR, dated 4/2024 and 5/2024, the record did not show any documentation or order to record the vital signs or BP in the MAR.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview with LN 6 on 5/9/24, at 10:25 AM, LN 6 stated the workflow on checking and assessing the vital signs was to notify the doctor if needed. LN 6 stated it was a basic nursing care function to address vital signs if not within normal range.<br><br>During an interview with Certified Nurse Assistant (CNA) 1 on 5/9/24, at 10:30 AM, CNA 1 stated one of her job functions was to measure and record the vital signs and not all resident's VS were recorded on daily basis. CNA 1 stated she recorded her measurements in a sheet of paper located at the nursing station. CNA 1 stated she would notify the licensed nurse if the VS were not normal.<br><br>During an interview with the Director of Nursing (DON) on 5/8/24, at 5:40 PM, the DON stated it was the doctor's responsibility to order vital sign monitoring parameters. The DON stated nursing staff followed the doctor's order.<br><br>During an interview with the DON on 5/9/24, at 4:03 PM, the DON stated Vital Sign (VS) recording was updated recently to include checking the VS every Monday and Wednesday and the previous policy was old. The DON stated she looked forward to incorporating monitoring parameters for high-risk drugs with the new planned electronic medical record roll out.<br><br>In a telephone interview with the Medical Doctor (MD) 1, on 5/9/24, at 5 PM, the MD 1 stated he usually did not order hold parameters (conditions in which nursing staff to hold the medication and/or call the doctor) for medication orders and the general parameters could not be applied to every resident. MD 1 stated there needed to be a standard protocol to double check the vital sign and contact the doctor if parameters were not within normal limit on a symptomatic or at-risk resident.<br><br>Review of the facility's policy titled, Facility Procedure: Medication Administration Record (MAR), with a revision date of 2/15/24, the policy indicated, Purpose: To administer appropriate medication to the correct patient with the correct dosage at the correct time and route. The policy, in the Procedure, section indicated, . Prepare medication and verify with the 6 rights of safe medication administration .Check apical pulse [or heart rate] or BP per physician orders . The policy did not elaborate on medications requiring vital sign monitoring without a doctor's order.<br><br>Review of the facility's policy titled,, Facility Policy: Medical Director, Responsibility Of, with a review date of 8/18/23, the policy indicated, The SNF [Skilled Nursing Facility] Medical Director (practitioner) is responsible for overseeing the implementation of resident care policies and the coordination of medical care in the facility to ensure to the extent possible that care is adequate and appropriate steps are taken to correct identified problems.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's policy titled, Vital Sign Policy, with a revision date of 2/15/24, the policy indicated, Vital signs are taken and documented on: each admission every shift for two weeks, every shift on residents on occurrence charting, every shift on all residents covered by Medicare A (government insurance), on care conference day vital signs with orthostatic Blood pressure (a form of low blood pressure might cause dizziness, lightheadedness or fainting when rising from sitting or lying down) checks will be taken for MDS (or Minimum Data Set, a report sent to federal government on resident status) assessment purposes. Residents on hypertensive medication will have the blood pressure monitored per MD orders. Resident with a stable BP will be monitored each week or per MD order. If blood pressure is outside of residents' normal range, MD will be notified, and vital sign will be monitored per MD orders. BP will be checked with each administration of hypertension medication if parameters are ordered. Vital signs may be taken at any time per nursing judgment. Abnormal findings will be reported to the MD. All residents will have vital signs taken and documented every month. A licensed nurse will check vital signs prior to administration of a medication for which parameters are ordered/indicated.<br><br>2. During a review of Resident 28's MAR, dated 5/2024, the MAR indicated a blood thinner medication called Eliquis (apixaban), ordered for twice a day administration since 8/21/23 for prevention of stroke. The order was highlighted as a Black Box Warning label with no explanation. Further review of the MAR did not show any monitoring parameters for nursing staff to watch for possible side effects on a daily basis.<br><br>Review of Resident 28's care plan (a nursing plan of care, with goals, and monitoring), the care plan under the problem column, last edited on 4/2/24, indicated, Resident 28 with Hx [history] of CVA [or Cerebral Vascular Accident, or brain stroke] with RX [Prescription] for Eliquis; potential for adverse s/e [side effects]. The care plan under the approach column, last edited on 4/10/23, indicated, Provide medication per orders. Assess for adverse effects and report .Assess skin integrity for bruises, skin tears, bleeding .<br><br>During an interview with the DON on 4/9/24, at 4:03 PM, the DON stated the medication monitoring including blood thinners were addressed on case-by-case basis per the doctor's order. The DON stated it was important to check for bleeding and/or bruises on the skin and report it to doctor.<br><br>Review of the facility's consultant Pharmacist (CP) record titled, Medication Regimen Review, dated from 4/13/23 to 3/19/24, the handwritten record for Resident 28, on 4/13/23, noted labs okay; Eliquis dose okay.<br><br>Review of the facility policy titled, Medications With Black Box Warning, with a revision date of 11/30/23, the policy under Intent indicated, To promote safe and effective use of medication with Black Box Warnings, nursing will identify symptoms that indicate a significant adverse reaction might be occurring . the policy on procedure section indicated, Medication side effects and/or Black Box Warning printouts will be used on the Medication Administration Record .Nursing will monitor for the described adverse drug reactions and report any suspected adverse drug reactions to the physician. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40903<br><br>Based on interview, and record review, the facility failed to ensure safe use and monitoring of psychotropic (mind altering drugs) medication in 3 out of 5 sampled residents (Resident 209, Resident 20, and Resident 1) reviewed for unnecessary medication when:<br><br>1. Resident 209's specific behavior monitoring, and expression of distress was listed as resistant to care which did not pose a harm to resident or others when the root cause of resistance to care may have been an attempt to communicate unmet needs and a discomfort unable to articulate to nursing staff,<br><br>2. Resident 209 and Resident 20's psychotropic drug dosage range did not fit the usual dose range for elderly residents with dementia diagnosis and were not discussed with Resident's Representatives; and<br><br>3. Resident 209 and Resident 1's anxiety medication called lorazepam (or Ativan, medication used to treat anxiety) for PRN or as needed basis (PRN or Latin word pro re nata means as the thing is needed) was renewed for 6 months or longer without any clinical justification for its use, risk, or the need.<br><br>These failures had the potential for unsafe medication use and monitoring.<br><br>Findings:<br><br>1. During a review of Resident 209's medical record titled, Medication Administration Record, (MAR, a document that listed medications to begiven and the daily monitoring) dated ,d+[DATE], the record indicated the following psychotropic orders and the resident specific behavior monitoring as follows:<br><br>Quetiapine tablet 25 mg (mg or milligram, a unit of measure; also known as Seroquel) .oral Twice a Day; Black Box Warning (or BBW- highest level of warning given to the drug when used in elderly with dementia) . [unspecified Dementia, unspecified severity, with other behavioral disturbance]; [DATE]- open ended<br><br>Quetiapine Target Behavior: Resistant to Care (R), Intrusiveness (I) Every Shift; [DATE]- Open Ended<br><br>The record did not specify the reason for resistant to care and why this behavior could have posed harm to the resident or others.<br><br>A review of Resident 209's medical record titled, Psychopharmacologic Drug Summary Sheet, (summary of use and monitoring of mind-altering drugs) dated ,d+[DATE], indicated two episodes of the resistance to care during the month of [DATE]. The record did not elaborate the root cause of the resistant to care and if it contributed to resident harm to self or others.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview with Certified Nursing Assistant (CNA) 4 on [DATE], at 1:50 PM, at Unit 6 hallway, CNA 4 stated Resident 209 felt uncomfortable when her body was exposed during showering, bathing, and peri care. CNA 4 stated Resident 209 was hard of hearing for her to understand the staff talking to her. CNA 4 stated Resident 209 was most anxious and uncooperative during shower time, and it took two persons to help with a shower. CNA 4 stated Resident 209 had gotten better with routine care and seeing the same care givers.<br><br>During an interview with the Director of Nursing (DON), on [DATE], at 5:40 PM, the DON stated the behavior to monitor had to be the one that could pose harm to resident or staff and residents had the right to refuse care. The DON stated the monitoring could have been worded differently.<br><br>In a telephone interview with Resident 209's Representative (RR) 1 on [DATE], at 1:40 PM, RR 1 stated Resident 209 was uncomfortable and fearful of bathing and the facility's staff had done a great job on calming her down.<br><br>2a. During a review of Resident 209's medical record titled, Facility Verification of Resident Informed Consent for .psychotherapeutic drugs ., dated [DATE], the record signed by MD 1, indicated Resident 209's legal representative gave consent for use of mind-altering drug called quetiapine with Potential Dose Range of 12.5mg to 800 mg for Diagnosis: dementia with behavioral disturbances such as resistant to care.<br><br>In a telephone interview with RR 1 on [DATE], at 1:40 PM, RR 1 stated Resident 209 was uncomfortable and fearful of bathing and the facility's staff had done a great job on calming her down. RR 1 stated the facility called her for changes in condition such as falling down or if she had a fever. RR 1 stated she did not recall receiving phone call about the medication use and the dosage of her mind-altering medications has not changed as far as she knew.<br><br>During an interview with LN 6 on [DATE], at 12:38 PM, LN 6 stated the admission workflow included addressing mind-altering medication use and the consent form. LN 6 stated as the resource nurse, after review of prior health records, she filled out the form which included resident specific behaviors and a dose range with minimum to maximum dose allowable. LN 6 stated she looked at the drug reference book to come up with a maximum dose range. LN 6 stated the paper consent form then was used by the doctor to sign and/or contact family and explain the mind-altering medication use.<br><br>During an interview with the DON on [DATE], at 4:53 PM, the DON stated the consent paper for mind-altering drug was prepared by the resource nurse for the doctor to sign and address. The DON stated the form which was created by the facility asked for a dosage range. The DON stated nurses used a drug information book to put a maximum allowable dose range on the form. The DON acknowledged maximum dosage for elderly dementia residents may not be the same as other mental health diseases.<br><br>2b. During a review of Resident 20's medical record titled, Facility Verification of Resident Informed Consent for .psychotherapeutic drugs ., dated [DATE], the record signed by MD 1, indicated Resident 20's legal representative gave consent for use of mind-altering drug called quetiapine with Potential Dose Range of 12.5mg to 750mg for Diagnosis: dementia with behavioral disturbances.<br><br>(continued on next page) |

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| | 555209 | A. Building<br>B. Wing | 05/09/2024 |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 20's medical record titled Medication Administration Record, (a document that listed medications to begiven and the daily monitoring) dated ,d+[DATE], the record indicated the following mind-altering psychotropic order: Quetiapine tablet 25 mg (also known as Seroquel) .oral Twice a Day; Black Box Warning .(or BBW- highest level of warning given to the drug when used in elderly with dementia) . [unspecified Dementia, unspecified severity, with other behavioral disturbance]; [DATE]- Open Ended.<br><br>In a telephone interview with Resident 20's Representative (RR) 2 on [DATE], at 11:17 AM, RR 2 stated he did not recall receiving any call from the doctor or the facility about medication use or dosage ranges as he was not closely involved with the detail of care provided.<br><br>During an interview with LN 6 on [DATE], at 12:38 PM, LN 6 stated the admission workflow included addressing mind-altering medication use and the consent form. LN 6 stated as the resource nurse, after review of prior health records, she filled out the form which included resident specific behaviors and a dose range with minimum to maximum dose allowable. LN 6 stated she looked at the drug reference book to come up with a maximum dose range. LN 6 stated the paper consent form then was used by the doctor to sign and/or contact family and explain the mind-altering medication use.<br><br>During an interview with the DON on [DATE], at 4:53 PM, the DON stated the consent paper for mind-altering drug was prepared by the resource nurse for the doctor to sign and address. The DON stated the form which was created by the facility asked for a dosage range. The DON stated nurses used a drug information book to put a maximum allowable dose range on the form. The DON stated most recently the facility had initiated a process to renew the consent for mind-altering medication use every 6 months. The DON acknowledged maximum dosage for elderly dementia residents may not be the same as other mental health diseases.<br><br>Review of the online drug information UpToDate [NAME] Drug, on quetiapine medication use in elderly, last accessed on [DATE], it indicated, Avoid for behavioral problems associated with dementia or delirium unless alternative nonpharmacologic [Nondrug approaches] therapies have failed, and patient may harm self or others. If used, consider deprescribing attempts to assess continued need and/or lowest effective dose. The document under dosing for Agitation/Aggression and psychosis associated with dementia, indicated Oral: Initial: 25 mg at bedtime; may increase dose gradually (eg, weekly) based on response and tolerability up to 75 mg twice daily. The facility's staff were not using an age and diagnosis appropriate dose range per doctor's assessment of resident's medication needs.<br><br>3a. During a review of the Resident 209's medical record titled, Medication Administration Record [MAR], dated ,d+[DATE] and ,d+[DATE], the MAR record indicated orders for lorazepam as follows:<br><br>lorazepam 0.5 mg table; 0.5 mg, oral, As Needed, PRN, QHS (at bedtime); For Generalized anxiety disorder; Start date: [DATE]; Stop Date: [DATE].<br><br>lorazepam 0.5 mg tablet; 0.5 mg, oral, As Needed, PRN, QHS; Generalized anxiety disorder; Start Date: [DATE]; Stop Date:[DATE].<br><br>Further review of the record indicated the lorazepam was renewed on [DATE] for a duration of 6 months after a 15-day trial. The MAR record indicated evening time restlessness by resident and no documentation of non-drug approaches prior to using the PRN lorazepam and renewal for 6 more months.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 209's MAR further indicated the lorazepam which was ordered for bed-time use was administered between 6:30 PM to 7:25 PM.<br><br>Review of the Resident 209's medical record titled, Status Change Notification and /or Orders, dated [DATE], the paper record which was faxed to Medical Doctor (MD) 1's office indicated, Request for Orders; Res. (Resident 209) Lorazepam order expired on [DATE]; Would you like to extend for another 6 months? . signed by a nurse. The record signed by MD 1 with a note Cont. (Continue) PRN lorazepam x 6 Mon. (for 6 months) for chronic anxiety; dated [DATE].<br><br>Review of Resident 209's medical record titled, Nurse's Progress Note, dated [DATE], the record written on [DATE], at 6:56 AM, indicated, Resident noted with statement of I am Dizzy x2 times per CNA (Certified Nurse Assistant) report, Plus her gait is unsteady, shuffles backward .<br><br>In an interview with facility's Consultant Pharmacist (CP) on [DATE], at 12:50 PM, the CP stated she had been asked to review medication profile if they could contribute to the fall. The CP stated she reviewed the medication profile once a month and shared her finding with DON and medical doctor if indicated.<br><br>During an interview with the DON on [DATE], at 9:49 AM, the DON stated the Medical Doctor made the decision to use or continue duration of the medications. The IDT team (Intradisciplinary Team- a group of clinical staff who reviewed and addressed resident specific progress and challenges) reported the resident care issues to the team and medical director to review them.<br><br>3b. During a review of the Resident 1's medical record titled, Medication Administration Record, (or MAR) dated ,d+[DATE], the MAR record indicated an order for lorazepam as follows:<br><br>lorazepam .0.5 mg, oral, As Needed, BID (twice per day) PRN; For anxiety disorder; Start date: [DATE]; Open Ended.<br><br>Further review of the MAR indicated the medication was administered twice a day regularly with a nursing note indicating the Reason Behavior was being Stressed despite non-drug approaches.<br><br>Further review of Resident 1's MAR, dated ,d+[DATE] and ,d+[DATE], indicated Resident 1 was receiving 3 other opioid medications concurrently with lorazepam as follows:<br><br>Oxycodone 10 mg (strong pain medication) every 4 hours around the clock,<br><br>Methadone 10 mg (strong and long-acting pain medication) Twice daily,<br><br>Morphine 5 mg (strong pain medication) as needed (Given once or twice per day).<br><br>Further review of administration record by nursing staff, indicated these three opioid medications were administered within 1 hour of lorazepam use.<br><br>Review of Resident 1's Care Plan document (a document that listed resident's plan of medical and mental health care and progress), dated 2021- 2023, the care plan indicated the same dose and frequency of lorazepam since [DATE].<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the MD 1's progress note, dated [DATE], the note indicated a long list of medical problems including Chronic Pain and noted Stable on present regimen of methadone, Percocet, liquid morphine for severe breakthrough symptoms. The note listed lorazepam was used as needed for anxiety and muscle spasm. The note did not document risk versus benefits of using lorazepam on as needed basis when resident was using it regularly.<br><br>Review of Resident 1's medical record titled Quarterly Interdisciplinary Resident Care Conference, dated [DATE], the record indicated use of lorazepam 0.5 mg BID PRN [twice daily as needed] and it was included in the Black Box Meds list along with the opioid pain medications (Black Box Med same as Black Box Warning (BBW) issued by FDA [Food and Drug Administration], a US agency that regulated drug use as its highest level of warning given to a drug for the risks it may pose).<br><br>In an interview with MD 1 on [DATE], at 5:03 PM, MD 1 stated Resident 1's opioid use in combination with lorazepam had been challenging as resident refused to accept any changes. MD 1 stated he kept the lorazepam on an as needed basis although Resident 1 had been taking it twice daily regularly. MD 1 stated overall he had reduced the opioid burden during Resident 1's stay at the nursing home.<br><br>In an interview with CP on [DATE], at 12:50 PM, the CP stated she reviewed the medication profile once a month and shared her finding with DON and medical doctor if indicated. The CP shared her note to MD 1, dated [DATE], which indicated It's required the care center attempt a Gradual Dose Reduction (GDR) quarterly unless clinically contraindicated .Patient is also on baclofen 10 mg [drug used for muscle spasm] QID (Four times Daily] for muscle spasm. The note did not have a response from MD 1 as of [DATE]. The CP stated Resident 1's opioid medication use had been reduced by half since he was admitted to the facility in April of 2019.<br><br>Review of the FDA's web site titled, FDA requiring Boxed Warning updated to improve safe use of benzodiazepine drug class [same class as lorazepam], dated [DATE], and last accessed on [DATE] via https://www.fda.gov/drugs/fda-drug-safety-podcasts/fda-requiring-boxed-warning-updated-improve-safe-use-benzodiazepine-drug-class, the warning indicated Health care professionals should consider the patient's condition and other medicines being taken, and assess the risk of abuse, misuse, and addiction when prescribing benzodiazepines. Caution should be taken when prescribing with opioids and other medicines that depress the central nervous system.<br><br>Review of the facility's policy titled Psychopharmacologic [Mind altering drugs] Drug Summary, last revised on [DATE], the policy indicated, Monitor psychotropic [mind altering] drugs for effectiveness in controlling targeted behaviors and associated adverse drug reactions .When psychopharmacologic drugs are used, the following shell apply: 1. PRN orders for such drugs shall be subject to the requirements of this section. 2. The data collected shall be made available to the prescriber in a consolidated manner at least monthly .4. The specific behavior manifestation of disordered thought process to be treated with the drug is identified in the resident's health record. 5. Prior to administration of psychotropic drugs, a consent is obtained and kept on file. The policy referenced federal and state regulations at the end. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43071<br><br>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food practices in accordance with professional standards for food service safety for a total of 59 residents who received food from the kitchen when:<br><br>1. A half-filled pancake mix container was expired and available for use in the kitchen; and<br><br>2. A double oven located in the kitchen was not clean.<br><br>These failures placed facility residents at risk of food borne illnesses (eating or drinking something that is contaminated with germs that can cause illness) and had a potential of fire hazard.<br><br>Findings:<br><br>1. During an initial tour of the kitchen on [DATE], at 9:28 AM, the Production Supervisor (PS) verified a half-filled pancake mix container on a rack in the kitchen was labeled with use by date of [DATE]. The PS stated it was expired. The PS further stated expired food should be thrown away and should not be available for use.<br><br>During an interview on [DATE], at 3:50 PM, the PS stated expired food should not be available to use for food safety. The PS stated there was a risk of serving expired food to the residents. The PS further stated expired food would make residents sick and could cause food borne illness.<br><br>Review of a facility policy titled, Food Storage revised [DATE], indicated, .To ensure the hospital stores food and nutrition products using proper sanitation, temperature, light, moisture, ventilation, and security .All stored food must be properly labeled and dated with .Use-by date .The use-by day or date marked may not exceed the manufacturer's use-by date .Dry or staple items, including spices, must be used by the manufacturer ' s use-by date .<br><br>2. During a continued initial tour of the kitchen on [DATE], at 9:28 AM, the PS verified the double ovens in the kitchen were not clean and had cooked on grease. The PS stated ovens were cleaned only as needed. The Lead Food Services Associate (LFSA) stated ovens were cleaned weekly.<br><br>During an interview on [DATE], at 3:50 PM, the PS stated the double ovens were not cleaned to their standards and could have been cleaned better. The PS stated unclean ovens posed a risk of cross contamination (transfer of harmful bacteria from one person, object, or place to another) and food borne illness.<br><br>Review of a facility policy titled Ovens/Toasters, revised [DATE], indicated, .Ovens/Toasters will be operated safely and efficiently to bake and roast food products. They will be cleaned daily and deep cleaned weekly to prevent fires and odor development .OVEN .SANITATION .Daily .Weekly (deep clean) . |

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| F 0825<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or get specialized rehabilitative services as required for a resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50161<br><br>Based on interview, and record review, the facility failed to provide Physical Therapy (PT- the treatment of disease, injury, or deformity by physical methods such as message, heat treatment, and exercise) as ordered by the physician for one of three sampled residents (Resident 309) with physical therapy orders when, Medical Director (MD) 1 had ordered PT on 4/26/24 for Resident 309, but the services had not yet been provided by the PT department.<br><br>This failure resulted in the potential for Resident 309 for not attaining and maintaining their highest possible level of physical and functional well-being. This failure also had the potential to delay necessary treatment and delay necessary assistive services needed for Resident 309.<br><br>Findings:<br><br>Review of Resident 309's Resident Face Sheet, indicated Resident 309 was admitted to the facility on [DATE] with diagnosis which included but not limited to history of falling, other sequelae of cerebral infarction (stroke; blood supply to the brain is blocked or reduced and prevents brain tissue from getting oxygen and nutrients), pain in the left hip, and muscle weakness (generalized).<br><br>During an interview on 5/6/24, at 9:58 a.m., Resident 309 stated that that he had a stroke a few years back and was supposed to be receiving physical therapy. Resident 309 stated that he has not been receiving physical therapy nor had he been seen by a physical therapist.<br><br>During an interview on 5/8/24, at 10:21 a.m., with Family Member (FM) 1, FM 1 stated that during the admission meeting with the facility, a facility representative stated that Resident 309 was going to be offered physical therapy because Resident 309 had two prior strokes and was dragging his right leg. FM 1 stated that Resident 309 was living with him prior to being admitted to the facility, but that Resident 309 was falling a lot at home, and it was no longer safe for him to live there.<br><br>Review of Resident 309's Physician Order Report, indicated that on 4/26/24 an order was placed by the MD 1 for Rehabilitation Therapy: Rehab Potential: Fair .PT (Physical Therapy) Referral and Treatment for RNA services [restorative nurse aide; provides rehabilitative care such as walking, exercise, and/or other activities for residents as recommended by the PT department].<br><br>During an interview with Licensed Nurse (LN) 8, on 5/8/24 at 11:06 a.m., LN 8 stated that she was aware that Resident 309 needed physical therapy and was told by the RNA that they were waiting for physical therapy to come do their assessment of Resident 309 before RNA services could start.<br><br>(continued on next page) |

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| F 0825<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 5/8/24, at 3:13 p.m., with the Physical Therapist Lead (PTL) and the Administrative Director (AD), Resident 309's physician orders were reviewed. The PTL stated that she was the lead in charge of the Physical Therapy Department for the hospital and the skilled nursing facility. The PTL stated she oversaw PT and came to the skilled nursing facility to perform her PT assessments when ordered by the doctor. The PTL stated that when there was a new admission, she received an email and the doctors order sets, which then generated the PT referral. She stated that the time frame for PT to assess a resident was one week. She stated that Resident 309 has been in the facility for two weeks and that she had not been able to come out to the skilled nursing facility to perform Resident 309's initial PT assessment. The PTL stated that PT and RNA therapy could be helpful for a resident adjusting to a new living situation such as when residents were newly admitted to the facility. The PTL was not aware that Resident 309 had a fall in the dining hall on 5/1/24.<br><br>During an interview on 5/8/24, at 3:40 p.m., with the AD, the AD stated her expectation was for a resident to be seen by a Physical Therapist within a week of a doctor's order. The AD stated that one week was a reasonable time period for PT to assess a resident.<br><br>Review of a facility policy and procedure (P&P) titled, FACILITY PROCEDURE: FUNCTIONAL MANAGEMENT CARE POLICY, revised 10/1/20, indicated, .[facility name] Skilled Nursing Units shall provide .restorative care to meet each resident's individual needs as required in each resident's plan of care . residents will receive care that enables them to achieve and/or maintain their highest practicable level of physical independence and provide a continuity of care .Functional Management (FM) primary focus is to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident and shall be directed to prevent deterioration .Therapies, Physical .Performs Therapy Evaluations and Treatments as ordered by physician .Works with Charge Nurse regarding appropriate FM goals and programs individualized for the resident, and trains CNA's [certified nursing assistant] if needed .Serve as educational resources . |

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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>40903<br><br>Based on observation, interview, and record review, the facility failed to ensure safe infection prevention practices for a census of 60 when:<br><br>1. When Licensed Nurse (LN) 8 carried the stock bottle of test strips (test strip used to measure blood sugar) into an isolation room (restricted room to prevent the spread of infection) without cleaning or sanitization before and after use,<br><br>2. Resident 309's urinal (a bottle used for urination) was not labeled with Resident 309's name or another identifier; and,<br><br>3. Resident 309 's urinary bag (a drainage bag attached to a catheter (tube) that is inside the bladder to collect urine) was hanging on Resident 30's walker.<br><br>These failed practices could contribute to spread of infection in the facility.<br><br>Finding:<br><br>During a medication administration observation with LN 8, in the facility's Unit 7, on 5/7/24, at 11:25 AM, LN 8 gathered the blood sugar measurement supplies including a glucometer (a device that measured blood sugar), test strip bottle (stock bottle of test strip; when single test strip was soaked with blood, inserted into glucometer to measure blood sugar), one lancet (single use small sharp needle-like device used to poke the finger to get drops of blood for sugar measurement), and alcohol pads (small sanitizing pad) into the Resident 20s room. Resident 20's room was marked with a sign Enhanced Barrier Precautions (meant before entering room one needed to use protective means to prevent spread of infection) and the sign indicated Clean Hands; Providers and Staff must also wear Gloves and Gown for High-Contact Resident care Activities. LN 8 placed the supplies including the bottle of the test strips, on bed-side counter while Resident 20 was sitting on a wheelchair. LN 8 removed one test strip from the container and attached it to the glucometer. When the test strip bottle fell on the floor, LN 8 picked it up and put it in her pants pocket till she exited the room. LN 8 did not clean and sanitize the outer surface of the test trip bottle when it was returned to the box container storing all blood sugar measurment supplies.<br><br>During an interview with LN 8, in Unit 7's hallway, on 5/7/24, at 11:40 AM, LN 8 stated she took the test strip bottle in the room just in case she needed to re-do the testing.<br><br>During an interview with Infection Prevention nurse (IP), in unit 7, on 5/7/24, at 11:52 AM, the IP stated the nurse should had taken only the needed supplies for testing blood sugar in the isolation room and the reusable items such as glucometer should be cleaned and sanitized. The IP stated the whole bottle of test strip should not have been taken into the isolation room.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's policy titled, Enhanced Standard Precaution for Skilled Nursing, dated 5/24/23, the policy on section D indicated, Implement Enhanced Standard Precaution for High Risk residents .Tasks: Wear gloves and gowns while performing the following tasks associated with the greatest risk of MDRO (or Multi-Drug Resistant Organism-infections that are resistant to antibiotics treatment) contamination of HCP's (Health Care Personnel) hands, clothes and the environment: a. Any care activity involving contact with environmental surfaces likely contaminated by the residents .C. Any care activity where close contact with the residents exposed to occur .<br><br>During a review of the facility's policy titled, Glucometer Cleaning/Disinfection, dated 12/12/19, the policy indicated, Blood glucose (sugar) monitors are cleaned and disinfected after each use in order to prevent cross contamination between patients. Disposable, self-retracting lancets (sharp device used to poke the finger for blood droplet) are used for staff safety .All meter external surfaces should be cleaned and disinfected with a bleach wipe between uses .Dispose of any used wipe and gloves in an appropriate container. Wash hands with soap and water . The policy did not address how to handle use of test strips or if the test strip bottle should have been cleaned /disinfected if taken inside a resident's room and/or an isolation room.<br><br>50161<br><br>Review of Resident 309's Resident Face Sheet, indicated Resident 309 was admitted to the facility with a diagnosis which included but not limited to, urinary tract infection (UTI).<br><br>During an interview and observation on 5/7/24, at 9:13 a.m., Resident 309 stated that he had a urinary foley catheter (a tube placed in the body to drain and collect urine from the bladder) for the last eight to nine months. Resident 309 stated that he emptied his urinary catheter bag himself into the urinal and would then leave the urinal that contained his urine hanging off the footboard and staff would come in and empty it. It was observed that there was a urinal that was one-third filled with a yellow liquid hanging off the footboard of Resident 309's bed. It was observed that the room was occupied by four residents.<br><br>During a concurrent interview and observation on 5/7/24, at 9:13 a.m., with the IP, the IP was observed picking up a urinal that was one-third filled with a yellow liquid that was attached to Resident 309's foot of bed. The IP stated the urinal must have belonged to another resident in the room and she did not know who the urinal belonged to or why it was on Resident 309's bed and stated it must have been placed there by mistake. Resident 309 stated to the IP that the urinal belonged to him, and he left it there for staff to empty. Resident 309 stated to the IP that he emptied his own urinary catheter bag into the urinal by himself. The IP stated that she was not aware that Resident 309 emptied his own urinal because he was a new admit. The IP confirmed that the urinal did not have the resident's name, or another resident identifier written on the urinal.<br><br>During a concurrent interview and observation on 5/8/24, at 10:01 a.m., with Certified Nurse Assistant 4 (CNA) in Resident 309's room, CNA 4 stated that Resident 309 liked to empty his own urinary catheter bag by himself. CNA 4 further stated that Resident 309 sometimes would let her know when the urinal was full. CNA 4 stated the urinal got changed weekly and that she would dump it out in the bathroom and clean it. CNA 4 further stated that usually the room number was listed on the urinal. CNA 4 stated Resident 309 was on Enhanced Barrier Precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555209 | A. Building<br>B. Wing | 05/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Adventist Health Sonora - D/P Snf | 179 South Fairview Lane<br>Sonora, CA 95370 |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview on 5/8/24, at 10:56 a.m., with LN 8 in Resident 309's room, LN 8 stated she must gown up to prevent infection for any resident who had a urinary catheter to prevent infection to the resident and confirmed that Resident 309 had a urinary catheter. LN 8 stated she was aware of Resident 309 being able to empty his own urine. LN 8 stated urinals should be labeled with the date and resident's name and that night shift usually changed the urinal once a month unless it was dirtied and soiled. LN 8 stated that if a urinal was not labeled with the resident's name, then the risk would be another resident grabbing it and using which could spread infection to the residents.<br><br>During an interview on 5/8/24, at 11:18 a.m., with the IP, the IP stated that the urinal should have listed the bed number on it to identify the resident it belonged to and was not sure how often the urinals were changed. The IP stated that the risk for not labeling the urinal would be that it could be interchanged by staff or other residents, and the risk could be cross-contamination of germs and infection that could cause a Urinary Tract Infection (UTI) in residents. The IP stated staff labeled items so they knew what resident the items belonged to.<br><br>During an interview on 5/9/24, at 1:08 p.m., with the IP and the Infection Prevention and Quality Director (ID), the IP stated that regarding Resident 309's urinal not being labeled with resident identifier that the risk would be not knowing who the urinal belongs to. The IP stated that Resident 309 was on EBP due to resident having a urinary catheter. The IP stated that Resident 309 was at higher risk of Multidrug Resistant Organisms (MDRO; germs resistant to medication used to treat infections) and that if Resident 309 had an infection it could spread to another resident in the room if his urinal was used by another resident. The IP stated the risk of not using identifier on urinal was that another resident or staff member could accidently use it for another resident. The IP stated that they did not want residents to share collection devices because they could share germs and the risk would be to all residents who share the room.<br><br>Review of a facility policy and procedure titled, FACILITY PROCEDURE: BEDSIDE ITEMS, dated 8/16/23, indicated, .Bedside items shall not be shared between residents to prevent the spread of infection Disposable items shall be marked with the resident's initials, room number and stored at their bedside .the following items may be kept at bedside .urinal<br><br>43071<br><br>3. During an observation on 5/7/24, at 1:14 PM, Resident 309 was observed eating lunch in the dining room. Resident 309's urinary bag was hanging on Resident 30's walker who was sitting next to him. Resident 309's walker was behind his chair about 2-3 feet (measure of distance) away. Resident 309 finished his meal and started to leave the dining room using his walker while his urinary bag was hanging on Resident 30's walker.<br><br>During continued observation on 5/7/24, at 1:16 PM, LN 7 walked into the dining room. LN 7 then grabbed Resident 309's urinary bag from Resident 30's walker and hanged it on Resident 309's walker.<br><br>During an interview on 5/7/24, at 1:18 PM, LN 7 confirmed Resident 309's urinary bag was hanging on Resident 30's walker. LN 7 stated Resident 309's walker should not have been placed at Resident 30's walker due to an infection control issue.<br><br>(continued on next page) |

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| Adventist Health Sonora - D/P Snf | 179 South Fairview Lane<br>Sonora, CA 95370 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/8/24, at 4:55 PM, the Director of Nursing (DON) stated she heard that Resident 309's urinary bag was found on Resident 30's walker. The DON stated it was not a clean practice and it was not Resident 30's belonging. The DON further stated it should not have been on her walker and it placed Resident 30 at risk for a fall.<br><br>Review of Resident 309's physician order dated 5/3/24, indicated Resident 309 was on enhanced barrier precautions due to urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag).<br><br>Review of a facility policy titled, ENHANCED STANDARD PRECAUTIONS FOR SKILLED NURSING, dated 12/12/19, indicated, .Always follow standard precautions, including .environmental infection control in all care setting for all residents .<br><br>Review of a facility policy titled, ISOLATION: STANDARD AND TRANSMISSION BASED PRECAUTIONS, dated 7/27/22, indicated, .Standard Precautions: Are a set of infection control practices that .reduce the risk of transmission (spread) of infectious agents to both healthcare personnel and patients in the healthcare setting .Standard precautions are utilized at all times with all patients regardless of patient status or diagnosis. All blood, body fluids, excretions, or secretions must be considered potentially infectious . |