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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 47914 Based on interview, record review, and facility policy review, the facility failed to complete a new preadmission screening and resident review (PASARR) when a resident received a new mental illness diagnosis for 2 (Resident #11 and Resident #35) of 4 sampled residents reviewed for PASARR. Findings included: A facility policy titled, Admission Criteria, revised 03/2019, revealed, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. 1. An Admission Record revealed the facility originally admitted Resident #35 on 02/03/2022. According to the Admission Record, the resident received diagnoses of schizophrenia and anxiety disorder on 07/14/2022. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/05/2024, revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was not evaluated by the state level II PASARR and determined to have serious mental illness and/or intellectual disability or a related condition. Per the MDS, during this assessment period, the resident had active diagnoses to include schizophrenia and anxiety disorder. Resident #35's care plan, initiated 07/19/2022, indicated the resident was at risk for altered mood related to schizophrenia. Resident #35's medical record revealed no evidence to indicate the resident was referred to the appropriate state-designated authority for PASARR evaluation once the resident was identified to have a new mental illness diagnosis. 45555 2. An Admission Record indicated the facility admitted Resident #11 on 02/27/2011. According to the Admission Record, the resident received a diagnosis of depression on 09/26/2022 and diagnoses of schizoaffective disorder and obsessive-compulsive disorder (OCD) on 09/27/2022. (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/05/2024, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had active diagnoses in the last seven days to include schizophrenia, depression, and obsessive-compulsive disorder. Resident #11's care plan, initiated on 07/30/2022 and revised on 06/28/2024, revealed the resident was at risk for altered mood related to diagnoses of depression, dementia, schizoaffective disorder, OCD and their overall health status. Resident #11's medical record revealed no evidence to indicate the resident was referred to the appropriate state-designated authority for a PASARR evaluation once the resident was identified to have a new mental illness diagnosis. During an interview on 07/03/2024 at 11:04 AM, the Social Services Director stated if she identified a resident had a need, change in condition, or a new diagnosis, she would notify the Director of Nursing (DON) or the Assistant Director of Nursing (ADON) so that a new Level I screening could be submitted. During an interview on 07/03/2024 at 11:11 AM, the DON stated when a resident had a new mental illness diagnosis, she or the ADON would be responsible to ensure a new Level I was submitted. she or someone else would complete a new PASARR screening and document the new diagnosis and medication and submit it. During an interview on 07/03/2024 at 11:46 AM, the Executive Director stated that if the resident had a change in condition, staff should complete another screening.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45555 Based on observation, interview, record review, and facility policy review, the facility failed to develop a person-centered care plan for 2 (Resident #16 and Resident #38) of 4 sampled residents reviewed for accidents and respiratory care. Specifically, the facility failed to care plan the use of bed rails and supplemental oxygen use for Resident #16 and failed to care plan the use of bed rails for Resident #38. Findings included: A facility policy titled, Care Plans, Comprehensive Person-Centered, revised 03/2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 1. An Admission Record revealed the facility readmitted Resident #16 on 06/26/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, Parkinson's disease, hypertensive heart and chronic kidney disease with heart failure, and atrial fibrillation. An observation on 06/30/2024 at 10:07 AM revealed Resident #16 lying in bed on their right side with half size bed rails in the up position on both sides of the upper end of the bed. An observation on 07/01/2024 at 10:24 AM revealed Resident #16 lying in bed on their right side, with supplemental oxygen on by way of a nasal cannula set at one liter. An observation on 07/02/2024 at 11:46 AM revealed Resident #16 lying in bed on their left side with half rails in the up position on both sides of the upper end of the bed. An observation on 07/03/2024 at 9:14 AM revealed Resident #16 lying in bed on their right side with half rails in the up position on both sides of the upper end of the bed. Resident #16's comprehensive care plan, with an admitted [DATE], did not reveal a care plan for the use of supplemental oxygen or bed rails. During an interview on 07/03/2024 at 9:14 AM, Licensed Vocational Nurse #1 stated the staff knew how to care for the residents by referring to their care plans. She stated the use of bed rails and supplemental oxygen should be included on the care plan. During an interview on 07/03/2024 at 10:34 AM, the Assistant Director of Nursing stated she was unsure if the use of bed rails needed to be included on the care plan, but stated supplemental oxygen use should be included on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/03/2024 at 10:49 AM, the Minimum Data Set (MDS) Assistant stated she care planned anything that triggered on the MDS assessment, to include medications, activities of daily living, and what type of assistance the resident needed. She stated the use of bed rails and supplemental oxygen should be included on the care plan. During an interview on 07/03/2024 at 11:11 AM, the Director of Nursing stated bed rails and supplemental oxygen use should be included on a resident's comprehensive care plan. During an interview on 07/03/2024 at 11:47 AM, the Executive Director stated he was unsure if bed rails needed to be included on the care plan, but the use of supplemental oxygen should be care planned. He stated it was the responsibility of the nursing staff to ensure the care plan was accurate and updated as needed. 29673 2. An Admission Record revealed the facility admitted Resident #38 on 06/13/2024. According to the Admission Record, the resident had a medical history that included diagnoses of other fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing, vascular dementia, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, encounter for orthopedic aftercare following surgical amputation, and history of falling. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/17/2024, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had impairment of both upper and lower extremities on one side and used a walker and wheelchair for mobility. The MDS indicated the resident was dependent on staff for transfers. An observation on 06/30/2024 at 10:54 AM revealed Resident #38 in bed with half size bed rails in the up position on both sides of the bed. An observation on 07/02/2024 at 10:50 AM revealed Resident #38 was asleep in bed with half size bed rails in the up position on both sides of the bed. Resident #38's comprehensive care plan, with an admitted [DATE], did not include a care plan for the use of bed rails. During an interview on 07/03/2024 at 11:20 AM, the Director of Nursing (DON) stated she was responsible for signing off on residents' care plans. The DON stated residents should have a care plan for bed rails if they were assessed to need them.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to have physician orders for the use of supplemental oxygen for 1 (Resident #16) of 3 sampled residents reviewed for respiratory care. Findings included: A facility policy titled, Oxygen Administration, revised 10/2010, specified, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. An Admission Record revealed the facility readmitted Resident #16 on 06/26/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, Parkinson's disease, hypertensive heart and chronic kidney disease with heart failure, and atrial fibrillation. Resident #16's Order Summary Report, for active orders as of 07/03/2024, revealed no order for the use of supplemental oxygen. An observation on 07/01/2024 at 10:24 AM revealed Resident #16 lying in bed on their right side, with supplemental oxygen on by way of a nasal cannula set at one liter. During an interview on 07/03/2024 at 9:14 AM, Licensed Vocational Nurse (LVN) #1 stated Resident #16 used their supplemental oxygen occasionally. LVN #1 stated there should be orders for the resident's use of supplemental oxygen. During an interview on 07/03/2024 at 10:34 AM, the Assistant Director of Nursing stated there should be an order for the use of supplemental oxygen. During an interview on 07/03/2024 at 11:11 AM, the Director of Nursing (DON) confirmed Resident #16 did not have an order for the use of supplemental oxygen, but received supplemental oxygen. The DON stated a physician order was required for the use of supplemental oxygen. During an interview on 07/03/2024 at 11:47 AM, the Executive Director stated there should be a physician's order for the use of supplemental oxygen.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure an assessment was completed and informed consent and a physician order was obtained for the use of bed rails for 1 (Resident #16) of 3 sampled residents reviewed for accidents. Findings included: A facility policy titled, Bed Safety, revised 08/2022, indicated, The use of bed rails is prohibited unless the criteria for use of bed rails have been met. The policy indicated, 2. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include: a. roll guards; b. foam bumpers; c. lowering the bed; and/or d. use of concave mattresses to reduce rolling off the bed. 3. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: a. an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs; b. the resident's risk associated with the use of bed rails; c. input from the resident and/or representative; and d. consultation with the attending physician. The policy indicated, 6. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. An Admission Record revealed the facility readmitted Resident #16 on 06/26/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, Parkinson's disease, hypertensive heart and chronic kidney disease with heart failure, and atrial fibrillation. Resident #16's Order Summary Report, for active orders as of 07/03/2024, revealed no physician orders for the use of bed rails. Resident #16's medical record revealed no evidence of an assessment for the use of bed rails since the resident readmitted to the facility on [DATE]. An observation on 06/30/2024 at 10:07 AM revealed Resident #16 lying in bed on their right side with half size bed rails in the up position on both sides of the upper end of the bed. An observation on 07/02/2024 at 11:46 AM revealed Resident #16 lying in bed on their left side with half rails in the up position on both sides of the upper end of the bed. An observation on 07/03/2024 at 9:14 AM revealed Resident #16 lying in bed on their right side with half rails in the up position on both sides of the upper end of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/03/2024 at 9:14 AM, Licensed Vocational Nurse (LVN) #1 stated if a resident requested bed rails, she would let maintenance know to put them on. She was unsure if an evaluation or consent was needed but stated a resident should have physician orders for the use of bed rails and confirmed that Resident #16 did not have a physician order for the use of bed rails. LVN #1 stated Resident #16's bed rails kept the resident from falling out of bed while they were positioned with pillows. During an interview on 07/03/2024 at 10:24 AM, Certified Nurse Assistant (CNA) #2 stated Resident #16 was able to hold the bed rail at times but otherwise required total assistance with their care. CNA #2 stated the rails prevented the resident from falling out of bed. During an interview on 07/03/2024 at 10:34 AM, the Assistant Director of Nursing (ADON) stated if a resident requested bed rails, she would let maintenance and the CNA know. The ADON stated if the resident were a fall risk, the rail would be a preference to assist the resident to reposition. The ADON stated permission would need to be obtained from the resident or family, and a physician order obtained for the bed rails. The ADON stated she was unsure how often a resident's use of bed rails was reassessed. The ADON stated Resident #16 could grab the rails sometimes and hold on a little bit, but the resident had the rails at the family's request when the resident's bed was switched to a hospice bed. During an interview on 07/03/2024 at 11:11 AM, the Director of Nursing (DON) stated there should be a physician's order and consent for the use of bed rails. The DON said if a resident needed or wanted bed rails; an assessment would also be completed to make sure the bed rails were used for enabling. The DON stated Resident #16 was not able to use the bed rails for repositioning and they were only on at the family's request. During an interview on 07/03/2024 at 11:47 AM, the Executive Director stated bed rails should not be used as restraints and assessments should be done but stated he would have to defer to the DON on what the assessment included and how often it should be done.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37683 Based on record review, interview, and facility policy review, the facility failed to ensure routine, scheduled pain medication was available in the facility for administration for 1 (Resident #73) of 2 sampled residents reviewed for pain management. Findings included: A facility policy titled, Pharmacy Services Overview, revised 04/2019, specified, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. The policy specified, 4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. An Admission Record revealed the facility admitted Resident #73 on 05/24/2023. According to the Admission Record, the resident had a medical history that included diagnoses of spinal stenosis (space inside the spine is too small that can cause pressure on the spinal cord and nerves), acute transverse myelitis in demyelinating disease of central nervous system (inflammation of the spinal cord), neuralgia (nerve pain) and neuritis (nerve inflammation), and muscle weakness. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/09/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had occasional pain during this assessment period and received scheduled pain medication regime and was offered and/received PRN (pro re nata, which meant as needed) pain medications. Resident #73's care plan, initiated 05/24/2023, indicated the resident was at risk for pain related to arthritis, peripheral vascular disease, neuropathies, chronic pain syndrome, amputation, diabetes, low back disorders, contractures, and fibromyalgia. Interventions directed staff to administer medications as ordered. Resident #73's Order Summary Report, for active orders as of 07/03/2024, revealed an order dated 11/13/2023, for morphine sulfate extended release oral tablet 30 milligrams (mg), one tablet by mouth two times a day for pain management. During an interview on 06/30/2024 at 3:30 PM, Resident #73 stated that the facility ran out of their pain medication towards the end of the month, and they had to wait for the doctor to order more. The resident stated that they did not get their scheduled pain medication the previous week for two and a half days. Resident #73's Rx [medical prescription] Reports, for the timeframe 06/01/2024 to 06/30/2024, indicated the facility received 12 tablets of morphine sulfateER on [DATE], and 30 tablets of morphine sulfateER on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #73's controlled drug administration record for 12 tablets of morphine sulfate that was delivered to the facility on [DATE], revealed documentation to indicate the last tablet was administered to the resident on 06/20/2024 at 9:00 AM. Resident #73's medication administration record (MAR) for the timeframe 06/01/2024 to 06/30/2024, the morphine sulfate ordered on 11/13/2023 was to be administered daily at 9:00 AM and 9:00 PM. The MAR revealed Licensed Vocational Nurse (LVN) #5, LVN #6, and LVN #3 documented a 9 for the 9:00 PM administration of the morphine sulfate on 06/20/204 and 06/21/2024 and for the 9:00 AM administration of the morphine sulfate on 06/22/2024, respectively. According to the MAR, 9 indicated other/see nurses [progress] notes. Resident #73's Progress Notes, dated 06/20/2024 at 9:11 PM, revealed the morphine sulfate was pending delivery. Resident #73's Progress Notes, dated 06/21/2024 at 9:19 PM, revealed the resident's morphine sulfate was not in the facility and staff were awaiting delivery from the pharmacy. Resident #73's Progress Notes, dated 06/22/2024 at 2:57 PM, revealed the resident's morphine sulfate was on order. During an interview on 07/01/2024 at 11:07 AM, Resident #73 confirmed they received oxycodone-acetaminophen when the morphine sulfate was not available. During a telephone interview on 07/01/02024 at 2:50 PM, LVN #6 stated she did not recall working at the facility or with Resident #73. LVN #6 stated she did not recall any issues with pain medication. During an interview on 07/01/2024 at 3:39 PM, Medical Doctor #8 stated a resident with pain should not be out of their scheduled pain medications. During a telephone interview on 07/01/2024 at 4:05 PM, LVN #5 stated that if a resident ran out of pain medications, she called the pharmacy immediately so they could contact the doctor for authorization. LVN #5 stated that if there were refills available, the pharmacy could send it right away. LVN #5 stated she usually contacted the pharmacy for refills when there were 10 to 12 tablets in the medication card remaining. LVN #5 stated that on the day she worked with Resident #73, someone had already ordered the scheduled morphine sulfate ER, but she did not know who ordered the medication or when it had been ordered. LVN #5 stated she offered another medication to the resident. During a follow-up interview on 07/02/2024 at 9:39 AM, LVN #5 stated that LVN #3 faxed the order to the pharmacy to refill Resident #73's morphine sulfate during the morning hours on 06/20/2024. During an interview on 07/02/2024 at 10:25 AM, LVN #3 stated medication refills could be requested through the electronic medical record. She stated the pharmacy usually delivered refilled medications on the same day or the following day, depending on when the refill was requested. LVN #3 did not remember who reordered the scheduled morphine sulfate ER for Resident #73, but did remember that it was not delivered for a couple of days. LVN #3 stated she contacted the pharmacy, and she also remembered the pharmacy was having issues with their fax at that time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 07/02/2024 at 10:50 AM, Pharmacist #9 stated Resident #73's morphine sulfate was delivered to the facility on [DATE]. According to Pharmacist #9, the order was written by the doctor on 06/20/2024, but the pharmacy did not receive the order until 06/22/2024 at 8:44 AM. During an interview on 07/02/2024 at 10:59 AM, the Director of Nursing (DON) stated that staff should not wait until a resident was out of their scheduled pain medications to reorder them. She stated that staff should order before the resident ran out of their medications. She stated that if staff noticed that the resident was out of scheduled pain medications, they should have called the pharmacy and said they needed the medications right away or contacted the doctor to request a signed authorization for the medication. The DON stated that the pharmacy fax was down on 06/20/2024, so the staff sent a picture of the order for Resident #73's morphine sulfate to the pharmacy. She stated that they could not find any documentation indicating that they requested a refill of the pain medication for Resident #73 prior to the resident running out of the morphine sulfate. During an interview on 07/03/2024 at 11:57 PM, the Executive Director (ED) stated that it was his expectation that medications should be refilled, but he deferred much of his expectations to the nursing staff. The ED stated residents should not go without their scheduled pain medications. During an interview on 07/03/2024 at 1:09 PM, the Medical Director stated residents should not go without their scheduled pain medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45555 Based on observation, interview, record review, manufacturer guideline review, and facility policy review, the facility failed to have a medication error rate less than 5%. The facility had 3 medication errors out of 30 opportunities, which yielded a medication error rate of 10% for 2 (Resident #30 and Resident #71) of 5 residents observed for medication administration. Findings included: A facility policy titled, Administering Medications, revised 04/2019 indicated, Medications are administered in a safe and timely manner, and as prescribed. Per the policy, 9. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dose, right time and right method (route) of administration before giving the medication. 1. The manufacturer guidelines titled, Instructions for Use for Admelog SoloStar insulin pen, revised 11/2019, specified, Step 3: Do a safety test. Always do a safety test before each injection to: * Check your pen and the needle to make sure they are working properly. * Make sure that you get the correct insulin dose. 3A Select 2 units by turning the dose selector until the dose pointer is at the 2 mark. 3B Press the injection button all the way in. * When insulin comes out of the needle tip, your pen is working correctly. If no insulin appears: * You may need to repeat this step up to 3 times before seeing insulin. * If no insulin comes out after the third time, the needle may be blocked. If this happens: - change the needle, - * then repeat the safety test. * Do not use your pen if there is still not insulin coming out of the needle tip. Use a new pen. An Admission Record revealed the facility admitted Resident #30 on 06/13/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus. Resident #30's Order Summary Report, with active orders as of 07/03/2024, revealed an order dated 04/09/2022, for Admelog solution 100 units per milliliter (ml) with instructions to inject two units subcutaneously two times a day for diabetes mellitus. During medication administration observation on 07/02/2024 at 8:21 AM, Licensed Vocational Nurse (LVN) #1 prepared and administered medications for Resident #30. At 8:48 AM, LVN #1 prepped the Admelog insulin pen and needle without performing the safety check of priming the needle with two units. LVN #1 turned the dose selector to two units and entered Resident #30's room to administer the insulin, but was stopped by the surveyor, prior to the dose being administered and questioned about priming the insulin needle. LVN #1 stated she did not think that she could prime the type of needle being used. After demonstration, LVN #1 put a new needle on the pen, primed it with two units and then turned the dose selector to two units and administered it to the resident. During an interview on 07/03/2024 at 9:14 AM, LVN #1 stated when she administered medications, she followed the five rights, right resident, right medication, right time, right dose, and right route, and then triple checked the label of the medication with the order on the medication administration record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555323	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviara Healthcare Center	944 Regal Road Encinitas, CA 92024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/03/2024 at 10:34 AM, the Assistant Director of Nursing stated she was not aware until recently that the insulin pen needle needed to be primed. During an interview on 07/03/2024 at 11:11 AM, the Director of Nursing stated she was aware that the insulin pen needed to be primed. During an interview on 07/03/2024 at 11:47 AM, the Executive Director stated the nurses should follow the manufacturers' recommendations for the use of the insulin pen. 2. An Admission Record revealed the facility admitted Resident #71 on 04/13/2023. According to the Admission Record, the resident had a medical history that included diagnoses of anemia and vitamin D deficiency. Resident #71's Order Summary Report, with active orders as of 07/03/2024, revealed an order dated 04/13/2023, for cholecalciferol (Vitamin D3) 1,000 units with instructions to give two tablets by mouth one time a day for supplementation and an order dated 04/13/2023, for multivitamin-minerals with instructions to give one tablet by mouth one time a day. During medication administration observation on 07/02/2024 at 9:13 AM, Licensed Vocational Nurse (LVN) #3 prepared and administered medications for Resident #71. LVN #3 administered Vitamin D 400 units one tablet (instead of 2,000 units as ordered) and failed to administer the multivitamin with minerals tablet. During an interview on 07/02/2024 at 11:55 AM, LVN #3 confirmed that she gave 400 units of Vitamin D instead of 2,000 units and stated she must have forgot the multivitamin with minerals because she was nervous. LVN #3 stated when she administered medications, she should check the label of the medication against the medication administration record to ensure she administered the right medication and double check to ensure she gave all the medications that were ordered. During an interview on 07/02/2024 at 2:27 PM, the Director of Nursing (DON) stated that she had a discussion with the staff that morning about following physician orders during medication administration. The DON stated the nurses should follow the five rights of medication pass, right resident, dose, medication, route, and time, to ensure all medications were administered according to the physician's orders. During an interview on 07/03/2024 at 10:34 AM, the Assistant Director of Nursing stated the nurses should compare the orders during medication pass to ensure they followed the physician's orders, and if they were unclear, then they should get clarification. During an interview on 07/03/2024 at 11:47 AM, the Executive Director stated the nurses should be following the physician order during medication administration.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to follow infection control procedures for the storage of respiratory equipment for 1 (Resident #16) of 3 sampled residents reviewed for respiratory care. Findings included: An undated facility policy titled, Departmental (Respiratory Therapy) - Prevention of Infection, indicated, 8. Keep the oxygen cannula and tubing used PRN [pro re nata, which meant as needed] in a plastic bag when not in use. The policy indicated for Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol, 7. Store the circuit in plastic bag, marked with date and resident's name, between uses. An Admission Record revealed the facility readmitted Resident #16 on 06/26/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, Parkinson's disease, hypertensive heart and chronic kidney disease with heart failure, and atrial fibrillation. An observation on 07/01/2024 at 10:24 AM revealed Resident #16 lying in bed on their right side, with supplemental oxygen on by way of a nasal cannula set at one liter. The yanker (used for suctioning) was noted on top of the dresser and the yanker tip touched the surface of the dresser. An observation on 07/02/2024 at 11:46 AM revealed Resident #16's nasal cannula touched the floor and the yanker tip was on the dresser, not stored appropriately. There was also a nebulizer mask on top of the plastic bag next to the nebulizer machine. During a concurrent observation and interview on 07/03/2024 at 9:14 AM, Resident #16's nasal cannula was noted on the floor, the yanker was on top of the dresser, and the nebulizer mask was on top of a plastic bag next to the nebulizer machine. Licensed Vocational Nurse (LVN) #1 entered Resident #16's room and stated the resident's oxygen tubing should not be on the floor and would need to be changed out before it was used again. LVN #1 stated the yanker should be stored in the package it came in and would need to be replaced as it was now contaminated. Per LVN #1, the nebulizer mask should be stored in a plastic bag and not on top of the plastic bag. During an interview on 07/03/2024 at 10:34 AM, the Assistant Director of Nursing stated respiratory equipment should be stored in a bag to protect it for infection control reasons. She stated the equipment should not touch a surface and should be replaced if it touched an unclean surface. During an interview on 07/03/2024 at 11:11 AM, the Director of Nursing (DON) stated supplemental oxygen supplies should be stored in a bag that was dated and should be changed out weekly. She stated the yanker should not touch a surface and the nasal cannula should not be on the floor and should be replaced. During an interview on 07/03/2024 at 11:47 AM, the Executive Director stated he would defer to the DON regarding the storage of respiratory equipment but expected the staff to follow the policy.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 37683 Based on record review, interview, facility policy review, the facility failed to ensure the influenza vaccine was offered to 1 (Resident #69) of 5 sampled residents reviewed for immunizations. Findings included: A facility policy titled, Influenza Vaccine, revised 03/2022, specified, 1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized. An Admission Record revealed the facility admitted Resident #69 on 03/11/2022. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke) affecting left non-dominant side, and dementia. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/24/2024, revealed that Resident #69 had a brief interview for mental status (BIMS) score of 2, which indicated the resident had severe cognitive impairment. The MDS revealed the resident received an influenza vaccine on 01/19/2023. Resident #69's immunization record revealed the resident received the influenza vaccine on 01/19/2023. There was no evidence to indicate the resident was offered the influenza vaccine between 10/01/2023 and 03/31/2024. During an interview on 07/03/2024 at 8:44 AM, the Infection Prevention (IP) Nurse stated the last influenza immunization the facility had documented for Resident #69 was 01/19/2023. The IP Nurse stated the resident should have been offered an influenza vaccination during the previous influenza season. The IP Nurse stated that it was important to get a new influenza vaccination for every flu season because different strains of flu could be circulating. During an interview on 07/03/2024 at 11:21 AM, the Director of Nursing (DON) stated influenza vaccines were administered annually and that was the expectation. She stated that consent forms were offered as soon as influenza season started and were administered when they were available by the pharmacy. The DON stated that it was important to provide influenza vaccines annually because there were different influenza strains every year. During an interview on 07/03/2024 at 11:57 AM, the Executive Director stated influenza vaccinations were offered on admission and annually because the influenza strains changed annually.