| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555328 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Fountain Valley Post Acute | 11680 Warner Avenue<br>Fountain Valley, CA 92708 |

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| F 0550<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to promote the dignity and respect for one of 30 final sampled resident (Resident 103) and one nonsampled resident (Resident 116).<br><br>* The facility failed to ensure the CNA was seated at eye-level while assisting Resident 103 with his meal.<br><br>* The facility failed to ensure the LVN was seated at eye-level while assisting Resident 116 with his meal.<br><br>These failures posed the risk of not treating the residents with dignity and respect.<br><br>Findings:<br><br>Review of the facility's P&P titled Assistance with Meals revised 3/2022 showed the residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example, not standing over residents while assisting them with meals.<br><br>1. Medical record review for Resident 103 was initiated on 11/4/24. Resident 103 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE].<br><br>Review of the H&P examination dated 12/22/23, showed the resident had no capacity to understand and make decisions.<br><br>Review of Resident 103's MDS dated [DATE], showed Resident 103's cognitive skills for daily decision making was assessed to be severely impaired with a BIMS score of 00 (according to the MDS RAI Manual, a score of 0-7 indicates the resident is severely cognitively impaired).<br><br>Review of Resident 103's care plan dated on 9/4/24, showed a care plan problem addressing the risk for deficits in communication, malnutrition, overweight, therapeutic diet, and thickened liquids with interventions in plan of care to evaluate the need for assistance with eating and drinking as needed.<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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0550<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | On 11/4/24 at 1240 hours, an observation and concurrent interview with CNA 5 was conducted in Resident 103's room during dining observation. Resident 103 was observed sitting upright in bed while CNA 5 was observed standing at bedside assisting with his meals. CNA 5 verified the finding and stated the staff should be sitting down when assisting with meals to ensure they were at the same level with the resident.<br><br>2. Medical record review for Resident 116 was initiated on 11/4/24. Resident 116 was admitted to the facility on [DATE].<br><br>Review of the resident's H&P examination dated 2/24/24, showed the resident had no capacity to understand and make decisions.<br><br>Review of Resident 116's MDS dated [DATE], showed Resident 116's cognitive skills for daily decision making was assessed to be severely impaired with a BIMS score of 00 (according to the MDS RAI Manual, a score of 0-7 indicates the resident is severely cognitively impaired).<br><br>Review of Resident 116's care plan dated on 3/4/24, showed a care plan problem addressing the nutritional risk for the potential for alerted nutrition and/or hydration status with interventions to evaluate the need for assistance with eating and drinking as needed.<br><br>On 11/4/24 at 1232 hours, an observation and concurrent interview with LVN 4 was conducted in Resident 116's room during dining observation. Resident 116 was observed sitting upright in bed while LVN 4 was observed standing at bedside assisting with his meals. LVN 4 verified the findings. LVN 4 stated she should be sitting down when assisting with meals to ensure they would be at the same level with the resident and for dignity.<br><br>On 11/7/24 at 1400 hours, an interview was conducted with the Administrator, DON, and Regional Quality Assurance Nurse. The DON stated the staff should be sitting down while assisting with meals to ensure dignity was maintained. The Administrator, DON, and Regional Quality Assurance Nurse acknowledged the above findings. |

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| F 0554<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one nonsampled resident (Resident 137) was assessed for self-administer medications and had an order and established care plan prior to self-administered the medication. This failure had the potential for unsafe medication administration.<br><br>Findings:<br><br>Review of the facility's P&P titled Self-Administration of Medications dated 2/2021 showed as part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medication is safe and clinically appropriate for the resident.<br><br>Medical record review for Resident 137 was initiated on 11/4/24. Resident 137 was admitted to the facility on [DATE].<br><br>On 11/4/24 at 0825 hours, a blue jar of Vicks vapor rub was observed on Resident 137's overbed table. Resident 137 applied the vapor rub to the temporal area of her head, both left and right. Resident 137 stated she used it sometimes for headaches.<br><br>On 11/4/24 at 1020 hours, RN 2 was summoned to the room and stated she was unaware of the Vicks vapor rub was left at the bedside.<br><br>On 11/4/24 at 1035 hours, an interview and concurrent record review was conducted with RN 2. RN 2 stated the resident had no physician's order for the use of Vicks vapor rub. There was no care plan for the self-administer medicine and self-administer assessment. RN 2 verified the findings. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179<br><br>Based on observation, interview, medical record review, and P&P review, the facility failed to ensure the call light was within reach for one of 30 final sampled resident (Resident 394) and one nonsampled resident (Resident 132). This failure had the potential for Residents 132 and 394 not receiving care timely.<br><br>Findings:<br><br>Review of the facility's P&P titled Answering the Call light dated 10/2010 showed when the resident is in bed or confine to a chair be sure the call light is within easy reach of the resident.<br><br>1. Medical record review for Resident 394 was initiated on 11/4/24. Resident 394 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>On 11/4/24 at 0815 hours, Resident 394 was awake with his call light on the floor. Resident 394 stated he could not locate his call light to call for the nurse. Resident 394 stated he needed help to change his diaper because his diaper was wet.<br><br>On 11/4/24 at 0825 hour, CNA 7 was summoned to the room. CNA 7 acknowledged the call light was on the floor and stated she would help the resident to change diaper. CNA 7 verified the findings.<br><br>2. Medical record review for Resident 132 was initiated on 11/4/24. Resident 132 was admitted to the facility on [DATE].<br><br>On 11/6/24 at 0815 hours, Resident 132 was observed looking for her call light. Resident 132 stated she could not find her call light. The resident's call light was observed on the wheelchair next to her bed and out of reach. Resident 132 stated she needed help to cut the toasted bread.<br><br>On 11/6/24 at 0840 hours, CNA 4 was summoned to the room and acknowledged the call light was on the wheelchair. CNA 4 verified the findings. |

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| F 0576<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure residents have reasonable access to and privacy in their use of communication methods.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the mail package was delivered unopened as per the facility's policy for one of four residents (final sampled resident, Resident 57) interviewed during the resident council meeting. This failure had the potential for the resident's mental anguish.<br><br>Findings:<br><br>Review of the facility's P&P titled Mail Delivery dated May 2024 showed the purpose of this policy is to ensure that all patients in skilled nursing facilities receive their mail promptly and securely, while maintaining their privacy and dignity.<br><br>Medical record review for Resident 57 was initiated on 11/5/24. Resident 57 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 57's H&P examination dated 5/29/24, showed Resident 57 had the capacity to understand and make medical decisions.<br><br>On 11/5/24 at 1124 hours, during the resident council meeting, Resident 57 stated recently, the Central Supply Clerk had delivered an open mail package to her, and because the package was open, it made her feel uncomfortable.<br><br>On 11/6/24 at 1507 hours, an interview was conducted with the Central Supply Clerk. The Central Supply Clerk stated she did open Resident 57's mail package by mistake because she thought it was her since she had ordered supplies for the facility and received many packages. The Central Supply Clerk did not check the name on the packages, but when she realized it was not her, she did bring the package to Resident 57 and apologized for the mistake. The Central Supply Clerk confirmed the package had been opened by the staff before Resident 57 received it and it should not have been. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of two final sampled residents (Resident 76) who was readmitted to the facility had a Level 1 PASARR screening. This failure had the potential of not providing the residents screened for mental illness or intellectual disabilities with additional resources if needed.<br><br>Findings:<br><br>Review of the facility's P&P titled PASARR revised 3/2019 showed all individuals are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process.<br><br>a. The facility verifies with the acute care hospital if a Level I PASARR screen for potential admissions and readmissions, regardless soft payer source, to determine if the individual meets the criteria for a MD, ID or RD.<br><br>b. Before a resident can be transferred from an acute care hospital, they must undergo a PASARR Level I screening. This initial screening is designated to identify individuals who may have mental illness (MI), intellectual disability (ID), or related conditions. The goal is to determine whether they require further evaluation (Level II) to assess the need for specialized services.<br><br>c. If the Level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process.<br><br>Medical record review for Resident 76 was initiated on 11/4/24. Resident 76 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE].<br><br>Review of the resident's H&P examination dated 9/11/24, showed the resident had no capacity to understand and make decisions.<br><br>Further review of Resident 76's Order Summary Report dated 11/4/24, showed the following physician orders:<br><br>- an order dated 9/11/24, to administer Risperdal (mood medication) 0.25 mg via GT every 12 hours for schizophrenia (mental disorder that impairs the way reality is perceived) manifested by seeing people that not there.<br><br>- an order dated 9/10/24, to administer trazodone (depression medication) 50 mg one tablet via GT at bedtime for depression manifested by inability to maintain sleep.<br><br>- an order dated 10/10/24, to administer escitalopram oxalate (depression medication) 5 mg two tablets via GT once day a day for depression manifested by tearfulness.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 76's medical record showed no documented evidence a PASARR Level I screening was completed upon the resident's admission back to the facility on [DATE].<br><br>On 11/7/24 at 1032 hours, an interview and concurrent medical record review for Resident 76 was conducted with SSA 1. SSA 1 stated the social service department reviewed if the residents had a PASARR upon admission from the acute care hospital and stated PASARRs would be completed for new admission, transition to hospice, or for a change of condition. SSA 1 further stated the last PASARR screening was conducted on 9/29/23; however, a PASARR was not completed on 9/10/24, when the resident was admitted back to the facility. SSA 1 stated a PASARR Level I screening should have been completed and she would complete the Level I screening today.<br><br>On 11/7/24 at 1040 hours, an interview and concurrent medical record review for Resident 76 was conducted with SSA 2. SSA 2 stated PASARRs identified any mental illnesses and disabilities. Level I screening evaluated the residents on psychiatric medications and determined if the residents needed a Level II screening. SSA 2 further stated a positive Level II screening determined if additional resources could be offered for the residents determined to have mental illness or disability. SSA 2 also verified Resident 76 did not have a current PASARR Level I screening after the resident's admitted [DATE], and stated one should have been done.<br><br>On 11/7/24 at 1400 hours, an interview was conducted with the Administrator, DON, and Regional Quality Assurance Nurse. The Administrator, DON, and Regional Quality Assurance Nurse acknowledged the above findings. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive person-centered care plans were developed and implemented for five of 30 final sampled residents (Residents 34, 43, 63, 76, and 743) as evidence by the following:<br><br>* The facility failed to develop and implement an EBP care plan for Resident 34.<br><br>* The facility failed to develop and implement an oxygen care plan for Resident 63.<br><br>* The facility failed to develop and implement a LAL mattress for Resident 76.<br><br>* The facility failed to develop and implement an EBP care plan for Resident 743.<br><br>* Resident 43's care plan for the use of oxygen showed to administer continuous oxygen at a rate of 2 liters per minute, however, the nursing staff failed to implement the care plan, as evidenced by having administered continuous oxygen therapy to Resident 43 at a rate of 1.5 liters per minute.<br><br>These failures had the potential of not providing residents with person-centered plan of care.<br><br>Findings:<br><br>Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed 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. The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The P&P further showed the comprehensive, person-centered care plan reflects currently recognized standards of practice for problem areas and conditions. Assessments of residents are ongoing and care plan are revised as information about the residents and the residents' conditions change.<br><br>1. Medical record review for Resident 34 was initiated on 11/4/24. Resident 34 was admitted to the facility on [DATE].<br><br>Review of the resident's H&P examination dated 9/5/24, showed the resident had the capacity to understand and make decisions.<br><br>Review of Resident 34's Order Summary Report dated 11/4/24, showed the following physician orders:<br><br>- an order dated 9/2/24, for an indwelling urinary catheter to monitor for change in urine character.<br><br>- an order dated 9/2/24, for the indwelling urinary catheter bag be in privacy bag and catheter leg strap on at all times.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - an order dated 9/2/24, for the indwelling urinary catheter size 16 Fr/10 ml bulb monitor for placement, change PRN if leaked, clogged, dislodged.<br><br>Further review of Resident 34's care plans showed no documented evidence a care plan was developed and implemented for EBP.<br><br>On 11/5/24 at 0910 hours, an interview and concurrent medical record review with LVN 1 was conducted. LVN 1 verified Resident 34 had an indwelling urinary catheter. LVN 1 stated the residents with the indwelling urinary catheters, GT, open wounds, or IV lines were expected to be on EBP and there should be a care plan. LVN 1 further verified there was no documented evidence Resident 34's care plan was developed and implemented for EBP and stated there should be a care plan.<br><br>2. Medical record review for Resident 63 was initiated on 11/4/24. Resident 63 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE].<br><br>Review of the resident's H&P examination dated 6/10/24, showed the resident had no capacity to understand and make decisions.<br><br>Further review of Resident 63's Order Summary Report dated 11/4/24, showed the following physician orders:<br><br>- an order dated 10/16/24, may administer oxygen at 2 liters per minute (may titrate up to 4 liters per minute) via NC PRN to maintain the oxygen saturation level greater than 92%.<br><br>On 11/5/24 at 1453 hours, an interview and concurrent medical record review with LVN 2 was conducted. LVN 2 verified Resident 63 had an order for oxygen PRN. LVN 2 further verified there was no documented evidence a care plan for the use of the oxygen was developed and implemented for Resident 63. LVN 2 stated there should be a care plan for the oxygen use. LVN 2 stated the care plans would focus on a concern that needed to be addressed and include the interventions and goals in how to care for the resident.<br><br>3. Medical record review for Resident 76 was initiated on 11/4/24. Resident 76 was admitted to the facility on [DATE], and readmitted to the facility on [DATE].<br><br>On 11/4/24 at 0910 hours, Resident 76 was observed lying on a LAL mattress.<br><br>On 11/4/24 at 1025 hours, an interview and concurrent medical record review with LVN 7 was conducted. LVN 7 verified Resident 76 was lying on a LAL mattress. LVN 7 further verified there was no documented evidence a care plan for the use of LAL mattress was developed and implemented. LVN 7 stated the LAL mattress should have been care planned.<br><br>4. Medical record review for Resident 743 was initiated on 11/4/24. Resident 743 was admitted to the facility on [DATE].<br><br>Further review of Resident 743's Order Summary Report dated 11/5/24, showed the following physician orders:<br><br>- an order dated 10/27/24, may insert a midline for IV access stat.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - an order dated 10/27/24, to monitor the IV site every shift for the sign and symptoms of infection (redness, swelling, warmth, pain) every shift.<br><br>- an order dated 10/27/24, to the change (PICC - peripherally inserted central catheter /Midline Central - a thin, flexible tube inserted into a vein in the upper arm to deliver fluids or medication into the blood stream) dressing site: cleanse with PICC Dressing Kit with biopatch and waterproof transparent dressing every week on Sundays for IV therapy.<br><br>On 11/5/24 at 1015 hours, an interview and concurrent medical record review with LVN 4 was conducted. LVN 4 verified Resident 743 had a midline to her right upper arm. LVN 4 stated the residents with a midline catheter, PICC, GT, indwelling catheters, and immunocompromised should be placed on EBP and should have a care plan for the EBP. LVN 4 further verified there was no documented evidence a care plan for EBP was developed and implemented for Resident 743.<br><br>On 11/7/24 at 1400 hours, an interview was conducted with the Administrator, DON, and Regional Quality Assurance Nurse. The DON stated the care plans provided the staff interventions on how to care for the residents. The Administrator, DON, and Regional Quality Assurance Nurse acknowledged the above findings.<br><br>37726<br><br>5. Medical record review for Resident 43 was initiated on 11/4/24. Resident 43 was admitted to the facility on [DATE].<br><br>Review of Resident 43's physician's order dated 9/26/24, showed to administer continuous oxygen via nasal cannula at 2 liters per minute for fluid overload.<br><br>Review of Resident 43's care plan titled Respiratory initiated 9/27/24, showed to administer oxygen at a rate of 2 liters per minute via nasal cannula.<br><br>On 11/4/24 at 1006 hours, an observation, interview, and concurrent medical record review was conducted with LVN 8. LVN 8 verified Resident 43's continuous oxygen was being administered at a rate of 1.5 liters per minute, via nasal cannula. LVN 8 verified Resident 43's Respiratory care plan showed to administer oxygen via nasal cannula at a rate of 2 liters per minute, for fluid overload. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064<br><br>Based on observation, interview, and facility P&P review, the facility failed to ensure one of one final sampled resident (Resident 60) who needed a communication board (pre-printed board that has pictures, numbers, and user defined images that allows a resident to point or indicate on the board what he/she wants communicated) to communicate the needs was provided with the communication board in the resident's language to communicate care needs to the facility staff. This failure had the potential to result in a delay of care services and needs for Resident 60.<br><br>Findings:<br><br>Review of the facility's P&P titled Communication Barriers and Communication Boards undated showed the facility will make arrangement for interpreters and/or alternate means of communication such as communication boards with pictures, common basic words, sign language, Braille, etc., to enhance communication between the resident and staff.<br><br>Medical record review for Resident 60 was initiated on 11/5/24. Resident 60 was admitted to the facility on [DATE].<br><br>Review of Resident 60's H&P examination dated 8/20/24, showed Resident 60 had the capacity to understand and make decisions.<br><br>On 11/4/24 at 0848 hours, an observation and concurrent interview was conducted with Resident 60. CNA 1 was observed talking to Resident 60 and using hand gesture to inform Resident 60 that CNA 1 would assist Resident 60 to be pulled up in bed. Resident 60 was observed turning to the surveyor asking the surveyor in Vietnamese what CNA 1 said to him. There was no communication board in Vietnamese observed at bedside or in the resident's room.<br><br>On 11/5/24 at 1100 hours, an observation and interview was conducted with the DON. The DON verified Resident 60 spoke Vietnamese and there was no communication board in Vietnamese language at bedside or in the resident room.<br><br>On 11/6/24 at 1001 hours, an interview was conducted with LVN 1. LVN 1 verified there was no communication board in Vietnamese language at bedside or in the resident's room. LVN 1 stated the Activity Director would place a communication board for the resident in the language that the resident needed.<br><br>On 11/6/24 at 1015 hours, an interviewed was conducted with the DON for Resident 60. The DON stated there should be a communication board in Resident 60's room so the staff would communicate with Resident 60. The DON stated the communication board would help Resident 60 to communicate his specific needs. |

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| | 555328 | A. Building<br>B. Wing | 11/07/2024 |

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| Fountain Valley Post Acute | 11680 Warner Avenue<br>Fountain Valley, CA 92708 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure three of three final sampled residents (Residents 43, 62, and 76) with high risk for skin breakdown were provided the necessary care and services as evidence by the following:<br><br>* The facility failed to ensure Resident 76's LAL mattress setting was not appropriate to the resident's weight.<br><br>* The facility failed to ensure the use of LAL mattress with specific direction for settings for Residents 43 and 62.<br><br>These failures had the potential for the residents not to receive the appropriate care and services to promote skin healing.<br><br>Findings:<br><br>Review of the facility's P&P titled Beds, Special - Low Air Loss Therapy, undated, showed it is the policy of this facility to utilize low air loss therapy under the direction of a physician's order. Facility staff working directly with the low air loss therapy unit will have training in its use by a company representative or a trained facility staff member.<br><br>Review of the facility document titled Medline Operation Manual, undated, showed users can adjust the pressure level of the air mattress to a desired firmness by themselves or according to the suggestion from a health care professional. It is recommended to press Auto Firm on the panel when the mattress is first inflated. Users can then easily adjust the air mattress to a desired firmness according to the patient's weight and comfort.<br><br>1. Medical record review for Resident 76 was initiated on 11/4/24. Resident 76 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE].<br><br>Review of Resident 76's H&P examination dated 9/11/24, showed the resident had no capacity to understand and make decisions.<br><br>Review of Resident 76's Order Summary Report dated 11/4/24, showed the following physician order:<br><br>- dated 9/11/24, for the sacrococcyx skin integrity, to cleanse with normal saline, pat to dry, apply thin layer of skin barrier cream and leave open to air one time daily.<br><br>Further review of Resident 76's Order Summary Report dated 11/4/24 failed to show a physician's order for the LAL mattress.<br><br>On 11/4/24 at 0910 hours, during an observation, Resident 76 was in bed lying on a LAL mattress with the mattress pressure setting set at 660 to 750 pounds.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/4/24 at 0928 hours, a concurrent observation and interview with Resident 76 and the DON was conducted in Resident 76's room. When Resident 76 was asked if she was comfortable with the mattress she was laying on, Resident 76 replied, sometimes ok and sometimes not. The DON verified the mattress pressure setting was set at 660 to 750 pounds. The DON further verified Resident 76 did not weigh between 660 to 750 pounds; however, she would verify the resident's current weight.<br><br>On 11/4/24 at 0935 hours, a concurrent observation and interview with the DON was conducted in Resident 76's room. The DON returned to Resident 76's room and adjusted the LAL mattress pressure setting to 290 pounds. The DON stated the mattress pressure setting was adjusted to the resident's tolerance and comfort. The DON stated the mattress pressure setting for Resident 76's should be set at 290 pounds.<br><br>On 11/4/24 at 1025 hours, a concurrent interview and medical record review was conducted with LVN 7. LVN 7 stated Resident 76 was lying on a LAL mattress with the mattress pressure setting now at 290 pounds. LVN 7 further stated Resident 76 weighed 285.3 pounds. LVN 7 stated the mattress pressure setting should be based on the resident's weight to prevent skin breakdown.<br><br>On 11/7/24 at 1400 hours, an interview was conducted with the Administrator, DON, and Regional Quality Assurance Nurse. The DON stated a physician's order was needed for LAL or specialty mattresses. The DON further stated LAL or specialty mattresses would be used to for the residents with pressure ulcers or to prevent skin breakdown. The Administrator, DON, and Regional Quality Assurance Nurse verified the above findings.<br><br>37726<br><br>2. Medical record review for Resident 43 was initiated on 11/4/24. Resident 43 was admitted to the facility on [DATE].<br><br>On 11/4/24 at 1010 hours, an observation, interview, and concurrent medical record review, was conducted with LVN 8. Resident 43 was observed lying in bed on a LAL mattress. LVN 8 stated at this time, Resident 43 had no pressure ulcers and the LAL mattress was utilized as a preventative intervention (to prevent the development of pressure ulcers). The LAL mattress was observed with several different setting options. LVN 8 was asked how she determined what setting Resident 43's LAL mattress should be set at. LVN 8 stated Resident 43's physician's orders and/or care plan should show the appropriate setting. LVN 8 then reviewed Resident 43's medical record and stated Resident 43 did not have a physician's order for the use of LAL mattress. Additionally, LVN 8 verified Resident 43 did not have a care plan specific to the LAL mattress settings.<br><br>3. Medical record review for Resident 62 was initiated on 11/4/24. Resident 62 was admitted to the facility on [DATE].<br><br>Review of Resident 62's care plan titled Skin initiated 9/28/24, showed Resident 62 was at risk for skin breakdown.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/4/24 at 1250 hours, an observation, interview, and concurrent medical record review was conducted with LVN 8. Resident 62 was observed lying in bed on a LAL mattress. LVN 8 was asked what setting Resident 62's LAL mattress should be programmed. LVN 8 then reviewed Resident 62's medical record and stated she would need to contact the physician to obtain an order specific to the use (and settings) of the LAL mattress for Resident 62. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the safe respiratory care to meet the needs for eight of eight final sampled residents (Residents 5, 43, 57, 63, 68, 110, 595, and 793) and one nonsampled resident (Resident 72) reviewed for respiratory care<br><br>* The facility failed to ensure Resident 793's physician's order for the use of CPAP machine was followed up with and failed to ensure Resident 793 was utilizing the CPAP machine as ordered by the physician. In addition, the facility failed to ensure Resident 793's nasal cannula was stored in a sanitary manner.<br><br>* The facility failed to ensure Resident 5's nasal cannula was changed as per the facility procedures and Resident 5's nebulizer mask storage bag was labeled per the facility policy.<br><br>* The facility failed to ensure Resident 57's CPAP and nebulizer mask were stored in a sanitary manner when not in use.<br><br>* The facility failed to ensure Resident 72's nebulizer mask was stored in a sanitary manner when not in use.<br><br>* The facility failed to ensure Resident 595's oxygen tubing was labeled, stored in respiratory bag and placed a signage Oxygen in Use outside on the door of Resident 595's room.<br><br>* The facility failed to follow the physician's order for the administration of continuous oxygen for Resident 43.<br><br>* Resident 110's nasal cannula was observed lying on the floor.<br><br>* The facility failed to administer oxygen as per physician's order to Resident 68 and change the nasal cannula oxygen tubing weekly.<br><br>* The facility failed to ensure Resident 63 had a storage bag for the oxygen and the storage bag for the nebulizer was labeled and dated as per the facility's P&P.<br><br>These failures had the potential to affect the respiratory health and well-being of the residents in the facility.<br><br>Findings:<br><br>Review of the facility's P&P titled Storage of BiPAP (Bilevel Positive Airway Pressure) and CPAP Masks and Tubing undated showed each resident's BiPAP/CPAP mask and tubing should be stored in individually labeled containers or personal belongings bag to prevent cross-contamination. Labels should include the resident's name, room number, and the date.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's P&P titled Administering Medications through a Small Volume (Handheld) Nebulizer revised 10/2010 showed the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. When the equipment is completely dry, store in a plastic bag with the resident's name and date on it. Change equipment and tubing every seven to 10 days, or according to facility protocol.<br><br>1. During an initial tour of the facility on 11/4/24 at 0907 hours, Resident 793's nasal cannula tubing was observed hanging around the right side of the resident's bed frame. Resident 793 stated she needed a new nasal cannula because it was on the floor. Resident 793's CPAP was not observed at the bedside.<br><br>On 11/4/24 at 1010 hours, an interview and concurrent observation was conducted with LVN 7. LVN 7 verified Resident 793's nasal cannula should be stored in a bag and labeled.<br><br>On 11/4/24 at 1152 hours, an interview was conducted with the ADON. The ADON acknowledged the above findings. The ADON stated the nasal cannula tubing should be changed weekly or if soiled and should be stored in a bag and labeled with name and date when it was changed. The ADON stated they did this to make sure it was clean and for infection prevention.<br><br>Medical record review for Resident 793 was initiated on 11/4/24. Resident 793 was admitted to the facility on [DATE], with diagnoses including obstructive sleep apnea.<br><br>Review of Resident 793's H&P examination dated 10/27/24, showed the resident used oxygen supplement at night and was not on CPAP.<br><br>Review of Resident 793's Order Summary Report for November 2024 showed a physician's order dated 10/23/24, for CPAP to be used at bedtime with a setting of three, and off in AM; and another order dated 10/23/24, for oxygen at three liters per minute via nasal cannula when off CPAP every shift.<br><br>Review of Resident 793's care plan failed to show a care plan focus was developed to address Resident 793's obstructive sleep apnea or need for the use of CPAP machine.<br><br>Review of Resident 793's Admission/Re-admission Summary Note dated 10/23/24, showed Resident 793 was admitted from the emergency department of the acute care hospital without CPAP and medication list. According to the resident's family member, they would bring medication prescription bottle from home and CPAP probably in AM. According to Resident 793, I have concentrator oxygen at home and I used that if I don't use CPAP.<br><br>Further review of Resident 793's medical record failed to show a follow-up was conducted regarding obtaining Resident 793's CPAP machine. In addition, the medical record failed to show the physician was contacted regarding Resident 793 not using or having a CPAP machine in the facility.<br><br>On 11/6/24 at 1534 hours, a follow-up interview was conducted with Resident 793. Resident 793 stated she did not have her CPAP machine in the facility and used oxygen instead of the CPAP machine. Resident 793 stated her CPAP machine was broken and at home.<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 - Some | On 11/6/24 at 1542 hours, a concurrent interview and medical record review was conducted with LVN 10. LVN 10 verified Resident 793 did not have a CPAP at bedside and had current active physician's orders for the use of CPAP machine. LVN 10 verified Resident 793's need for the CPAP machine was not followed up, nor was the physician notified regarding Resident 793 not using the CPAP machine as ordered.<br><br>On 11/7/24 at 1001 hours, the DON was informed and acknowledged the above findings.<br><br>2. During an initial tour of the facility on 11/4/24 at 0939 hours, Resident 5's nasal cannula tubing was observed stored in a plastic bag and labeled 9/24. Additionally, Resident 5's nebulizer mask was observed being stored in an unlabeled plastic bag.<br><br>On 11/4/24 at 1010 hours, an interview and concurrent observation was conducted with LVN 7. LVN 7 verified the above findings.<br><br>On 11/4/24 at 1152 hours, an interview was conducted with the ADON. The ADON acknowledged the above findings. The ADON stated the nasal cannula tubing should be changed weekly or if soiled, and the storage bags should be labeled with name and date when it had been changed.<br><br>Medical record review for Resident 5 was initiated on 11/4/24. Resident 5 was admitted to the facility on hospice services on 4/2/22.<br><br>Review of Resident 5's Order Summary Report dated 11/4/24, showed a physician's order dated 4/2/22, for oxygen as needed at two liters per minute, may titrate to four liters per minute to keep oxygen greater than 92% via nasal cannula; and another order dated 4/30/24, for sodium chloride inhalation nebulization solution 3% one vial via mask every six hours as needed for cough.<br><br>3. During an initial tour of the facility on 11/4/24 at 0955 hours, Resident 57's nebulizer mask was observed being stored on top of the nightstand. Additionally, Resident 57's CPAP mask was observed hanging on a hook attached to a shelf.<br><br>On 11/4/24 at 1010 hours, an interview and concurrent observation was conducted with LVN 7. LVN 7 verified the nebulizer mask and CPAP mask should be stored in a bag and labeled.<br><br>On 11/4/24 at 1152 hours, an interview was conducted with the ADON. The ADON acknowledged the above findings. The ADON stated the nebulizer mask and CPAP mask should be stored in a bag when not in use and labeled with name and date when it had been changed.<br><br>Medical record review for Resident 57 was initiated on 11/4/24. Resident 57 was readmitted to the facility on [DATE].<br><br>Review of Resident 57's Order Summary Report dated 11/4/24, showed the following physician's orders dated:<br><br>- 5/28/24, for CPAP machine to be on at HS and off AM with setting of five and oxygen use at two liters per minute.<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 - Some | - 7/22/24, for Brovana inhalation nebulization solution (medication used to assist with breathing) 15 mcg/2 ml one application inhale orally via nebulizer two times a day for COPD.<br><br>- 5/28/24, for ipratropium-albuterol inhalation solution (medication used to assist with breathing) 0.5-2.5 (3) mg/3 ml, three ml inhale orally via nebulizer every six hours as needed for wheezing/shortness of breath.<br><br>- 7/22/4, for Yuperlri inhalation solution (medication used to assist with breathing) 175 mcg/3 ml one application inhale orally via nebulizer one time a day for COPD.<br><br>4. During an initial tour of the facility on 11/4/24 at 0924 hours, Resident 72's nebulizer mask was observed stored on top of the nebulizer machine.<br><br>On 11/4/24 at 1010 hours, an interview and concurrent observation was conducted with LVN 7. LVN 7 verified the nebulizer mask should be stored in a bag and labeled.<br><br>On 11/4/24 at 1152 hours, an interview was conducted with the ADON. The ADON acknowledged the above findings. The ADON stated the nebulizer mask should be stored in a bag when not in use and labeled with name and date when t had been changed.<br><br>Medical record review for Resident 72 was initiated on 11/4/24. Resident 72 was readmitted to the facility on [DATE].<br><br>Review of Resident 72's MAR dated 10/2024 and 11/2024, showed Resident 72 received ipratropium-albuterol solution 0.5-2.5 (3) mg/3 ml one dose inhale orally via nebulizer four times a day for signs and symptoms of cough and shortness of breath from 10/23/24 until 11/4/24.<br><br>45064<br><br>5. Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed to place an Oxygen in Use sign on the outside of the room entrance door.<br><br>Reviewed of the facility's P&P titled Departmental Respiratory Therapy Prevention of Infection revised on 11/2011 showed to keep the oxygen cannulae and tubing used PRN in a plastic bag when not in use.<br><br>Medical record review for Resident 595 was initiated on 11/6/24. Resident 595 was admitted to the facility on [DATE].<br><br>Review of Resident 595's H&P examination dated 11/1/24, showed Resident 595 had the capacity to understand and make decisions.<br><br>Review of Resident 595's Order Summary Report dated 11/5/24, showed a physician's order dated 10/30/24, for oxygen at 2 liters per minute via nasal cannula every shift for pneumonia/pleural effusion.<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 - Some | On 11/4/24 at 1022 hours, an observation for Resident 595 was conducted. Resident 595 was observed sitting on the right side of the bed. Resident 595 nasal cannula was observed coiled without a bag on the oxygen concentrator undated and unlabeled on the right side of Resident 595 bedside.<br><br>On 11/4/24 at 1025 hours, an observation and concurrent interview for Resident 595 was conducted with LVN 1 at Resident 595's bedside. LVN 1 verified there was no date on Resident 595's nasal cannula and no respiratory storage bag. LVN 1 also verified there was no Oxygen in Use signage outside of the resident 595's room door. LVN 1 stated the nasal cannula should be labeled and stored in a bag to keep the nasal canula clean and know when to change it. LVN 1 stated the Oxygen in Use signage should be posted as a precaution for safety.<br><br>On 11/6/24 at 0840 hours, an interview was conducted with the DON. The DON stated the nasal canula should be labeled and placed in a bag when not in use. The DON further stated if the nasal canula was not labeled or stored in a bag the cannula might be exposed to bacteria and cause respiratory infection which could affected the resident health condition.<br><br>37726<br><br>6. Medical record review for Resident 43 was initiated on 11/4/24. Resident 43 was admitted to the facility on [DATE].<br><br>Review of Resident 43's physician's order dated 9/26/24, showed to administer continuous oxygen via nasal cannula at a rate of 2 liters per minute for fluid overload.<br><br>On 11/4/24 at 0933 hours, an observation was conducted of Resident 43. Resident 43 was observed lying in bed with continuous oxygen being administered at a rate of 1.5 liters per minute via nasal cannula.<br><br>On 11/4/24 at 1006 hours, an observation, interview, and concurrent medical record review was conducted with LVN 8. LVN 8 verified Resident 43's continuous oxygen was being administered at a rate of 1.5 liters per minute, via nasal cannula. LVN 8 verified the physician's order showed to administer continuous oxygen via nasal cannula at a rate of 2 liters per minute for fluid overload.<br><br>7. Medical record review for Resident 110 was initiated on 11/4/24. Resident 110 was admitted to the facility on [DATE].<br><br>Review of Resident 110's physician's order dated 10/7/24, showed to administer oxygen at a rate of 2 liters per minute via nasal cannula, to keep Resident 110's oxygen saturation level greater than 93%.<br><br>On 11/4/24 at 1240 hours, an observation was conducted of Resident 110. Resident 110 was observed lying in bed. An oxygen concentrator was observed adjacent to Resident 110's bed. The oxygen tubing and nasal cannula were observed attached to the oxygen concentrator. The nasal cannula was observed lying on the floor.<br><br>On 11/4/24 at 1300 hours, an observation and concurrent interview was conducted with LVN 8. Resident 110's nasal cannula was observed lying on the floor. LVN 8 verified the findings and stated Resident 110's nasal cannula needed to be stored in a clean bag for infection control.<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 - Some | 46787<br><br>8. During the initial tour on 11/4/24 at 0924 hours, an observation was conducted in Resident 68's room. Resident 68 was observed lying in bed receiving oxygen by nasal cannula at three liters per minute and the oxygen nasal cannula tubing was dated 10/22/24.<br><br>On 11/4/24 at 0930 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified the above findings and stated the oxygen nasal cannula tubing was to be changed weekly and it should have been changed.<br><br>Medical record review for Resident 68 was initiated on 11/4/24. Resident 68 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 68's H&P examination dated 8/28/24, showed Resident 68 had the capacity to make medical decisions.<br><br>Review of Resident 68's Order Summary Report for November 2024 showed a physician's order dated 8/26/24, for oxygen at two liters per minute through nasal cannula every shift for COPD.<br><br>Review of Resident 68's Care Plan problem addressing the resident's respiratory dated 8/27/24, showed an intervention for oxygen therapy as ordered for oxygen at two liters per minute through nasal cannula every shift for COPD.<br><br>On 11/6/24 at 0834 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON acknowledged and verified the above findings.<br><br>47474<br><br>9. Administering Medications Through a Small Volume (Handheld) Nebulizer P&P Revised 10/2010 showed the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Ask the resident to hold the mouthpiece gently between his/her lips (or apply face mask). When equipment is completely dry, store in a plastic bag with the resident's name and the date on it.<br><br>Medical record review for Resident 63 was initiated on 11/4/24. Resident 63 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE].<br><br>Review of the resident's H&P examination dated 6/10/24, showed the resident had no capacity to understand and make decisions.<br><br>Further review of Resident 63's Order Summary Report dated 11/4/24, showed the following physician orders:<br><br>- an order dated 10/16/24, may administer oxygen at 2 liters per minute (may titrate up to 4 liters per minute ) via nasal canula PRN to maintain oxygen saturation level greater than 92%.<br><br>- an order dated 6/6/24, for DuoNeb solution (medication used to assist with breathing) 0.5-2.5 mg/3 ml one vial inhale orally every six hours PRN for cough/congestion.<br><br>(continued on next page) |

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| Fountain Valley Post Acute | 11680 Warner Avenue<br>Fountain Valley, CA 92708 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/4/24 at 0835 hours, an observation and concurrent interview was conducted with LVN 7 in Resident 63's room. An observation of the storage bag for the nebulizer was observed not labeled or dated and there was no storage bag for Resident 63's oxygen. LVN 7 verified findings. LVN 7 stated the storage bags for the respiratory supplies should be dated and labeled and were provided to ensure they were changed and to decrease the risk of infection.<br><br>On 11/7/24 at 1400 hours, an interview was conducted with the Administrator, DON, and Regional Quality Assurance Nurse. The DON stated the storage bags for the respiratory supplies were changed weekly on Mondays. The DON further stated the weekly changes were done to prevent contamination and ensure infection control was maintained. The Administrator, DON, and Regional Quality Assurance Nurse acknowledged the above findings. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>39453<br><br>Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the disposed narcotic count sheets were signed by two licensed nurses. This failure had the potential for medication diversion (the illegal use or distribution of a prescription medication that was not originally intended by the prescriber).<br><br>Findings:<br><br>Review of the facility's P&P titled Discarding and Destroying Controlled/ Non-Controlled Medications revised 5/2024 showed the following:<br><br>-Medications that cannot be returned to the dispensing pharmacy (such as non-unit dose medications, medications refused by the resident, and/or medications left by residents upon discharge) are disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances; and<br><br>-Unless otherwise prohibited under applicable federal or state laws, individual resident medications supposed in sealed unopened containers may be returned to the issuing pharmacy for disposition provided that all such medications are identified as to lot of control number, and the receiving pharmacist and a registered nurse employed by the facility sign a separate log that lists the resident's name, the name, strength, prescription number if applicable, and the amount of the medication returned, and the date the medication was returned.<br><br>On 11/6/24 at 1530 hours, an interview and concurrent facility document review was conducted with RN 1. When asked about discarding the controlled medications, RN 1 stated the RN would write down the resident's name, controlled medication, and quantity to be discarded; and sign the log with another licensed nurse, then discard the controlled medications into the black narcotic box, to which RN 1 showed a copy of the Controlled Drugs Log.<br><br>Review of the Controlled Drugs Log showed 30 pieces of tramadol (opioid analgesic), nine pieces of tramadol, and 30 pieces of chlordiazepoxide (antianxiety) medications were placed inside the narcotic box on 11/5/24, but was only signed by one licensed nurse.<br><br>RN 1 verified the above findings.<br><br>On 11/6/24 at 1542 hours, an interview and concurrent facility document review was conducted with the DON. The DON verified the Controlled Drugs Log only showed one licensed nurse signed the log when discarding the tramadol and chlordiazepoxide medications into the narcotic box. The DON stated the Controlled Drugs Log should be signed by an RN and another licensed nurse. The DON stated the pharmacy consultant and RN would collect the controlled medications from the narcotic box for destruction. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of 30 final sampled residents (Residents 29 and 38) were free from the unnecessary drugs.<br><br>* Resident 29 received amitriptyline (antidepressant medication) and bupropion hydrochloride (antidepressant and smoking cessation); however, the facility failed to identify what target behaviors to monitor and did not monitor the episodes of behaviors for two antidepressant medications.<br><br>* The facility failed to document specific behaviors prior to prescribing Zoloft (antidepressant) and implement non-pharmacological interventions for Resident 38.<br><br>These failures had the potential for Residents 29 and 38 to have adverse complications from the medication.<br><br>Findings:<br><br>1. Review of the facility's P&P titled Psychotropic/Antidepressant Medication Use dated 2021 showed under the section Psychotropic Medication Management, Psychotropic medication management for the resident will involve the facility interdisciplinary team consideration of the following: indication and clinical need for medication, dose , duration and adequate monitoring for efficacy and adverse consequences.<br><br>Medical record review of Resident 29 was initiated on 11/4/24. Resident 29 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of the Order Summary report dated 11/6/24, showed a physician order dated 10/10/24, to administer amitriptyline hcl tablet 25 mg one tablet by mouth at bedtime for depression m/b (manifested by) verbalized of sadness. A physician order dated 10/10/24, to administer bupropion hydrochloride extended release 350 mg by mouth one time a day for smoking cessation for depression manifested by verbalization of sadness.<br><br>Review of the physician's order dated 7/19/24, showed an order for amitriptyline hydrochloride 25 mg one tablet by mouth at bedtime for depression m/b verbalized of sadness.<br><br>On 11/6/24 at 1520 hours, an interview and concurrent medical record review was conducted with the DON. The DON was asked about the reason that the resident received the amitriptyline and bupropion hydrochloride. The DON stated the amitriptyline for antidepressant and bupropion was used for antidepressant off label for smoking cessation. The DON was asked to provide the documentation of the behavior monitoring for the use of the amitriptyline and bupropion hydrochloride medications. The DON stated they did not monitor the episodes of the target behaviors for the two antidepressant medications were the same. The DON acknowledged it was difficult to monitor the same behavior to identify the effectiveness of both medications. The DON verified the findings.<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 - Few | On 11/7/24 at 0930 hours, an interview was conducted with LVN 5. LVN 5 stated for the last three days, Resident 29 had never verbalized any sadness to her.<br><br>On 11/7/24 at 1000 hours, an interview was conducted with CNA 3. CNA 3 stated Resident 29 had never verbalized any sadness or feeling depressed. Resident 29 had good relationship with the facility staff and roommate.<br><br>46787<br><br>2. Review of the facility's P&P titled Psychotropic/Antidepressant Medication Use undated showed the attending physician will identify, evaluate, and document, with input from other disciplines and consultants as needed, medical symptoms that may warrant the use of psychotropic medications. Psychotropic medication management for the resident will involve the facility IDT consideration, identifying person-centered non-pharmacological interventions to meet the individual needs of the resident, and minimize or discontinue the use of Psychotropic medication. The facility must attempt, and document non-pharmacological approaches attempted in the medical record.<br><br>Medical record review for Resident 38 was initiated on 11/4/24. Resident 38 was admitted to the facility on [DATE].<br><br>Review of Resident 38's H&P examination, undated, showed Resident 83 had the capacity to understand and make decisions.<br><br>Review of Resident 38's Order Summary Report dated active as of 11/4/24, showed a physician's order dated 10/10/24, for Zoloft 25 mg one time a day for depression manifested by verbalization of sadness.<br><br>Further review of Resident 38's medical record failed to show the following prior to the physician prescribing the Zoloft medication:<br><br>- documented behaviors of Resident 38 verbalizing sadness<br><br>- nonpharmacological interventions implemented prior to and during the use of Zoloft<br><br>On 11/7/24 at 1405 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON acknowledged and verified the above findings. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication rate was less than 5%. The facility's medication error rate was 12%.<br><br>* LVN 2 failed to administer Systane (eye drops, use for dry eyes) for Resident 22 as per the facility's P&P.<br><br>* LVN 4 failed to check Resident 12's bowel pattern for loose stool prior to administering docusate sodium (stool softener).<br><br>* LVN 1 failed to check Resident 97's bowel pattern for loose stool prior to administering docusate sodium.<br><br>Findings:<br><br>Review of the facility's P&P titled Administering Medications revised May 2024 showed the medications are administered in a safe and timely manner and as prescribed.<br><br>1. Review of the facility's P&P titled Eye Drops Administration Procedure undated showed ophthalmic solutions are administered into and around the eye in a safe and accurate manner. Release the eyelid and instruct the resident to close the eye for one or two minutes.<br><br>On 11/6/24 at 0930 hours, a medication observation pass was conducted for Resident 22 with LVN 2. LVN 2 prepared and administered Resident 22's Systane Ophthalmic Solution 0.4-0.3%, one drop to both eyes. Resident 22 was observed to close each eye for 10 seconds.<br><br>Review of Resident 22's Order Summary Report dated 11/6/24, showed a physician's order dated 9/26/24, for Systane Ophthalmic Solution 0.4-0.3%, instill one drop in both eyes every 12 hours for dry eyes.<br><br>On 11/6/24 at 0940 hours, an interview was conducted with LVN 2. LVN 2 acknowledged and verified Resident 22 was not instructed to close each eye for one to two minutes.<br><br>2. On 11/6/24 at 0947 hours, a medication observation pass was conducted with LVN 4 for Resident 12. LVN 4 prepared and administered Resident 12's medications which included the following:<br><br>- one tablet of amiodarone 10 mg (medication for abnormal heart rhythm),<br><br>- one tablet of vitamin C 250 mg (supplement),<br><br>- one tablet of aspirin 81 mg (supplement),<br><br>- one tablet of divalproex 500 mg (medication used to treat seizures),<br><br>- one softgel of docusate sodium 100 mg (stool softener),<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - one tablet of Felbamate 600 mg (medication used to treat seizures),<br><br>- one tablet of ferrous sulfate 325 mg (iron supplement),<br><br>- one tablet of renavite (supplement),<br><br>- one drop of refresh eye drops to each eye (medication for dry eyes), and<br><br>-t wo sprays of Flonase 50 mcg to each nostril (medication used to treat allergies).<br><br>Review of Resident 12's Order Summary Report dated active as of 11/4/24, showed a physician's order dated 12/28/22, for docusate sodium 100 mg one capsule by mouth two times a day for bowel management, and to hold for loose stool.<br><br>On 11/6/24 at 1000 hours, an interview and concurrent medical record review was conducted with LVN 4. LVN 4 acknowledged and verified she did not check Resident 12's bowel pattern for any loose stools prior to administering docusate sodium.<br><br>32179<br><br>2. Medical record review of Resident 97 was initiated on 11/4/24. Resident 97 was admitted to the facility on [DATE].<br><br>Review of the Order Summary Report dated 11/5/24, showed an order to administer docusate sodium oral capsule 100 mg two capsules by mouth two times a day for bowel management, and to hold for loose stool.<br><br>On 11/5/24 at 0835 hours, LVN 1 was observed administered docusate sodium to Resident 97 without asking when was the last bowel movement, frequency of bowel movement or the stool consistency was.<br><br>On 11/5/24 at 0900 hours, LVN 1 was informed of the observation of medication administration for the docusate sodium medication. LVN 1 acknowledged she did not ask the question to Resident 97 regarding the last bowel movement. LVN 1 verified the findings. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787<br><br>Based on observation, interview, and facility P&P review, the facility failed to ensure for the safe storage of the medications and supplies.<br><br>* The Central Supply Room was observed to contain expired supplies and medications along with other supplies without a manufacturing or expiration date.<br><br>* Medication Cart D was observed to contain multiple expired antifungal cream tubes.<br><br>* Medication Cart C was observed to contain a bottle of aspirin 81 mg without an expiration date and medication for a discharged resident.<br><br>* An antifungal cream was kept at the bedside for one final sampled resident (Resident 12).<br><br>*The facility failed to ensure Medication Cart E was not left unlocked and unattended.<br><br>* For Resident 82, facility failed to ensure A&D ointments (barrier cream/ointment) were not kept at Resident 82's bedside.<br><br>* The facility failed to dispose the discontinue medication for Residents who had been discharged for three nonsampled resident (Residents 54, 395, and 396).<br><br>* The facility failed to stored medication in safely and sanitary condition.<br><br>* The ointment were kept at the bedside for one final sampled resident (Resident 34).<br><br>These failures had the potential to result in the unsafe administration of medications.<br><br>Findings:<br><br>Review of the facility's P&P titled Storage of Medications revised ,d+[DATE] showed the facility stores all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.<br><br>1. On [DATE] at 1100 hours, an observation of the Central Supply Room was conducted with the Central Supply Clerk. The following items were observed in the Central Supply Room:<br><br>- one bottle of acetaminophen (analgesic) 500 mg + diphenhydramine hcl (antihistamine) 25 mg had expired on ,d+[DATE],<br><br>- one bottle of children's acetaminophen 160 mg/5 ml had expired ,d+[DATE],<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - one bottle of fish oil (supplement) 500 mg had expired ,d+[DATE],<br><br>- two tubes of Medline Inzo antifungal cream miconazole nitrate 2% had expired ,d+[DATE],<br><br>- one tube of Medline Inzo antifungal cream miconazole nitrate 2% had expired ,d+[DATE],<br><br>- one tube of Skin Integrity Hydrogel had expired ,d+[DATE],<br><br>- five tubes of Major ammonium lactate moisturizing lotion with no manufacturing or expiration dates, and<br><br>- 12 Medline Phytoflex Hydraguard silicone cream with no manufacturing or expiration dates.<br><br>The Central Supply Clerk verified the above findings.<br><br>2. On [DATE] at 1145 hours, an observation of Medication Cart D was conducted with LVN 6. The following items were observed in the Medication Cart:<br><br>- three tubes of Medline Inzo antifungal cream miconazole nitrate 2% had expired ,d+[DATE]<br><br>LVN 6 verified the above findings.<br><br>3. On [DATE] at 1215 hours, an observation of Medication Cart C was observed with LVN 3. The following items were observed in the Medication Cart:<br><br>- one bottle of aspirin 81 mg with no expiration date and<br><br>- three oral one ml syringes with cloudy fluid with the fill date of [DATE], for a discharged resident<br><br>LVN 3 verified the above findings.<br><br>On [DATE] at 1430 hours, an interview was conducted with the DON. The DON acknowledged the above findings.<br><br>4. During the initial tour on [DATE] at 0830 hours, an observation was made at Resident 12's bedside. One bottle of Medline Inzo antifungal cream, miconazole nitrate 2%, was observed on top of the bedside drawer.<br><br>On [DATE] at 1215 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified the above findings.<br><br>Medical record review for Resident 12 was initiated on [DATE]. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 12's MDS Section C dated [DATE], showed Resident 12 had severe cognitive impairment.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 12's Self-Administration of Medication Observation assessment dated [DATE], showed Resident 12 was not a candidate for self-administration of medications.<br><br>Further review of Resident 12's medical record showed no physician's order for the use of Inzo antifungal cream miconazole nitrate 2%.<br><br>On [DATE] at 0828 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified the above findings.<br><br>47476<br><br>5. Review of the facility's P&P titled Storage of Medications revised ,d+[DATE] showed unlocked medication carts are not left unattended.<br><br>On [DATE] at 0930 hours, Medication Cart E was parked in the hallway and observed unlocked and unattended. A resident was observed to pass by.<br><br>On [DATE] at 0932 hours, the DON verified Medication Cart E was left unlocked and unattended. The DON stated the medication cart should be locked.<br><br>32179<br><br>6. On [DATE] at 0840 hours, a medicine cup of white cream was observed on top of the bedside table of Resident 82. Resident 82 stated the staff would apply the cream to her buttock area after they were done changing her diaper.<br><br>On [DATE] at 1015 hours, RN 2 was summoned to Resident 82's room. RN 2 stated the A and D ointment should not be left at the bedside. RN 2 verified the findings.<br><br>7. On [DATE] at 0930 hours, an inspection of the Intravenous Cart was conducted with RN 3. The following items were observed in the Intravenous Cart:<br><br>- Two 12 ml syringes of heparin and one 10 ml syringes of normal saline were stored with laboratory tube and band aid,<br><br>- One package of Vial2Bag Advanced Admixture Devices was stored next to multiple pen, comb, keys, knife cutting paper.<br><br>- One bottle of 29.5 ml lorazepam (antianxiety) 2 gm/ml and one bottle of 3 ml morphine sulfate (opiod analgesic)100 mg/5 ml that belonged to Resident 54 .<br><br>- Multiple packages of denture cleanser stored next to multiple of needle gauges and Compact disc of diagnostic result of Residents.<br><br>- One opened bottle of aspirin.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | RN 3 verified the above findings. RN 3 stated the controlled substance should have been disposed as soon as possible and should not be kept at the Intravenous Cart. Resident 54 acknowledged Resident 54 had expired on [DATE].<br><br>Review of Resident 54's medical record review was initiated on [DATE]. Resident 54 was admitted to the facility on [DATE], and had expired on [DATE].<br><br>8. On [DATE] at 1000 hours, an observation of the Medication Storage Station 3 was conducted with the LVN 11. The following items were observed in the Medication storage:<br><br>- For Resident 395, one bottle of Montelukast singular (can treat allergies and prevent asthma attacks), one bottle of Movantik (used to treat constipation), one bottle of potassium (supplement), and one bottle of aspirin (nonsteroidal anti-inflammatory drug and blood thinners) 81 mg.<br><br>- For Resident 396, one bottle of cyclobenzaprine hydrochloride (muscle relaxant), one bottle of gabapentin (anticonvulsant) 30 mg, one bottle of paroxetine hydrochloride (antidepressant) 10 mg, one bottle of metformin (antidiabetic) 1000 mg, one bottle of Jardiance (antidiabetic) 10 mg,<br><br>- all medications of Resident 395 and 396 were stored with stethoscope, Pleura drainage kits, safety subcutaneous tissue infusion set, one fabric back leg back and zipper tag.<br><br>- Opened box of nicotine patch (18 patch) was unlabeled and stored to next to IV catheter and heparin lock flush syringe<br><br>- One of 600 ml Truclose gravity drainage bag with 20 inches inlet tube had expired on ,d+[DATE].<br><br>- An overflow medicine cabinet had CPAP machine stored with two bottle of magnesium citrate with black stain sticky at bottom of the bottle and two ounces a jar of cream was not labeled with resident name.<br><br>LVN 11 verified the above findings. LVN 11 stated Residents 395 and 396 had been discharged more than years ago. LVN 11 further stated these medicines should have been disposed as soon as possible or give back to the resident or resident's family when they were discharged .<br><br>Medical record review of Resident 395 was initiated on [DATE]. Resident 395 was admitted to the facility on [DATE], and discharged on [DATE].<br><br>Medical record review of Resident 396 was initiated on [DATE]. Resident 396 was admitted to the facility on [DATE], and discharged on [DATE].<br><br>47474<br><br>9. Medical record review for Resident 34 was initiated on [DATE]. Resident 34 was admitted to the facility on [DATE].<br><br>Review of the Resident 34's H&P examination dated [DATE], showed the resident had the capacity to understand and make decisions.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On [DATE] at 1145 hours, a concurrent observation and interview was conducted with Resident 34 and LVN 1 in Resident 34's room. The following was observed at bedside:<br><br>- One, opened, Z-Guard Paste ointment (to treat and prevent diaper rash and other minor skin irritations) with zinc oxide (a mineral) and white petrolatum (a moisturizing agent).<br><br>- Two vitamin A&D ointment (used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations)<br><br>LVN 1 verified the above findings. LVN 1 stated zinc oxide was considered a medication and the ointments should not be kept at bedside. LVN 1 stated the residents may have medications kept at the bedside if they had the physician's order and assessment for self-administration of medications. When Resident 34 was asked if she self-administered the ointments, Resident 34 replied she did not.<br><br>On [DATE] at 1400 hours, an interview was conducted with the Administrator, DON, and Regional Quality Assurance Nurse. The Administrator, DON, and Regional Quality Assurance Nurse acknowledged the above findings. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476<br><br>Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure the menu was followed when:<br><br>* The pureed fresh green salad with dressing was not served to 20 residents who were on pureed diets.<br><br>* Resident 46's lunch tray was observed with pureed food in accordance with the menu, except the fresh green salad with dressing was missing from the lunch tray. Additionally, Resident 46's lunch tray did not contain V8 juice puree.<br><br>* Resident 444's lunch tray was observed with pureed food in accordance with the menu, except the fresh green salad with dressing was missing from the lunch tray.<br><br>These failures had the potential to place 20 residents on pureed diets at risk of not receiving the menu as planned.<br><br>Findings:<br><br>Review of the facility's documented showed 20 residents received pureed diets prepared in the facility's kitchen.<br><br>1. Review of the facility's document titled Fall Menus, Week 2, Tuesday showed a pureed diet included: pureed lemon chicken piccata, pureed polenta, pureed spinach au gratin, and pureed fresh green salad with dressing.<br><br>Review of the facility's P&P titled Food Substitutions dated 5/2024 showed all substitutions are noted on the menu and filed in accordance with established dietary policies.<br><br>On 11/5/24 at 1030 hours, an observation of pureed meal preparation and concurrent interview was conducted with [NAME] 1 and the FSD. [NAME] 1 was observed to make the pureed lemon chicken piccata and pureed spinach au gratin. The pureed fresh green salad with dressing was not observed to be prepared. The FSD verified [NAME] 1 prepared only the pureed chicken and spinach and stated the polenta was already made.<br><br>On 11/5/24 at 1127 hours, a lunch tray line observation was conducted. There was no pureed fresh green salad with dressing placed on any of the trays to be served to the 20 residents on pureed diets.<br><br>On 11/5/24 at 1316 hours, the FSD verified they did not serve the pureed fresh green salad and stated they used a V8 juice instead of the pureed salad.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/5/24 at 1457 hours, a concurrent interview and facility document review was conducted with the FSD and RD 1. RD 1 verified the menu showed the residents with pureed diets would be served the fresh green salad with dressing. RD 1 stated for the fresh green salad, there was a recipe, and they follow the recipes. RD 1 verified they were supposed to be following the menus. The FSD stated they served the V8 juice instead. RD 1 stated the V8 juice was an appropriate alternative. The FSD asked RD 1 to sign the facility document titled Menu Substitution Record. RD 1 proceeded to initial the document. The facility document titled Menu Substitution Record showed the following:<br><br>- Menu Cycle Week Two, Tuesday, Lunch, 11/5/24<br><br>- Food item substituted: [NAME] salad pureed<br><br>- Food item omitted: V8 juice puree<br><br>- Reason for substitution: Lumpy when blends<br><br>- Initialed by RD 1<br><br>On 11/6/24 at 1436 hours, the FSD verified the V8 juice was not on the menu and verified the menu had not been changed.<br><br>On 11/7/24 at 1025 hours, an interview was conducted with the FSD and RD 2. RD 2 stated the V8 juice was a substitution, and they had no more salad at the time, so they did not notify the residents. The FSD stated it was an emergency and had to switch the salad out and let RD 1 know on the day of. The FSD further stated prior to the pureed preparation observation, they were prepping the pureed salad, and it did not work. The FSD stated they did not have any more stock to make the pureed fresh green salad.<br><br>37726<br><br>2. A lunch observation of Residents 46 and 444 was conducted on 11/5/24. Residents 46 and 444 were served pureed textured meals for lunch.<br><br>a. Medical record review for Resident 46 was initiated on 11/4/24. Resident 46 was admitted to the facility on [DATE].<br><br>Review of Resident 46's Order Summary Report showed an order for regular diet pureed texture, dated 11/4/24.<br><br>Review of Resident 46's care plan titled Nutritional Risk initiated 8/27/24, showed Resident 46 had the potential for altered nutrition related to cognitive deficits.<br><br>Review of Resident 46's Dietary Interview/Pre-Screen dated 8/27/24, showed Resident 46's food likes included salad.<br><br>Review of the facility's lunch menu (for 11/5/24) showed a pureed diet included: pureed lemon chicken piccata, pureed polenta, pureed spinach au gratin, and pureed fresh green salad with dressing.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/5/24 at 1309 hours, an observation and concurrent interview was conducted with CNA 9. Resident 46 was observed eating lunch. Resident 46's lunch tray was observed with pureed food in accordance with the menu, except the fresh green salad with dressing was missing from the lunch tray. Additionally, Resident 46's lunch tray did not contain V8 juice puree. CNA 9 verified the findings.<br><br>b. Medical record review for Resident 444 was initiated on 11/4/24. Resident 444 was admitted to the facility on [DATE].<br><br>Review of Resident 444's Order Summary Report showed an order for regular diet pureed texture, dated 11/6/24.<br><br>Review of Resident 444's care plan titled Speech Therapy initiated 11/4/24, showed diet texture modifications as indicated.<br><br>Review of Resident 444's Dietary Interview/Pre-Screen dated 11/6/24, showed Resident 444's food likes included salad.<br><br>On 11/5/24 at 1318 hours, an observation and concurrent interview was conducted with CNA 9. Resident 444 was observed eating lunch. Resident 444's lunch tray was observed with pureed food in accordance with the menu, except the fresh green salad with dressing was missing from the lunch tray. CNA 9 verified the findings. |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two nonsampled residents (Residents 14 and 132) observed during the dining observation received the appropriate mechanically altered diets (the texture of the diet is altered) as ordered by the physician.<br><br>* Resident 132 was not served the milk and coffee as ordered.<br><br>* Resident 14 was not served the correct diet as ordered.<br><br>This failure posed the risk of aspiration (inhalation of a foreign object into the airway and/or lungs) and resident's nutritional needs not being met.<br><br>Findings:<br><br>Review of the facility's P&P titled Food and Nutrition Services revised 10/2017 showed the food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature.<br><br>1. On 11/4/24 at 1157 hours, a meal cart was observed to be dropped off by the kitchen staff. LVN 7 was observed to check each tray's meal ticket (used to identify the resident's diet and food preferences for meal service) and a printout of the physician's diet orders. LVN 7 did not check the food served on the residents' meal trays. After he checked all the meal trays, LVN 7 was asked how he checked the food trays. LVN 7 stated he checked the meal ticket and the physician's order on the Diet Type Report.<br><br>On 11/4/24 at 1218 hours, Resident 14 was observed in her room and her meal tray was observed to be prepared in front of her. Resident 14's meal ticket stated her diet order was a mechanical soft (a texture modified diet, foods are made soft and easy to chew), regular diet. Resident 14's tray was observed with a regular texture diet.<br><br>On 11/4/24 at 1220 hours, a concurrent observation and interview was conducted with the ST. The ST observed Resident 14's tray. When asked if Resident 14 was provided a mechanical soft diet, the ST attempted to cut the meat and vegetables on the tray with a fork. The ST was observed to be unable to cut through the meat or vegetables. The ST verified Resident 14 was not served a mechanical soft diet.<br><br>On 11/4/24 at 1231 hours, the FSD verified Resident 14 was not served the correct diet and was served a regular diet. The FSD verified she needed to change Resident 14's food tray.<br><br>Medical record review for Resident 14 was initiated on 11/4/24. Resident 14 was readmitted to the facility on [DATE].<br><br>(continued on next page) |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 14's Order Summary Report dated 11/4/24, showed a physician's order dated 4/14/22, for a regular diet, mechanical soft texture, double protein with meals.<br><br>Review of Resident 14's plan of care showed a care plan focus revised 5/16/24, addressing Resident 14's nutritional status and modified diet texture per the speech language pathologist. The interventions included to provide the diet as ordered, regular, mechanical soft.<br><br>Review of Resident 14's Rehab - Dysphagia Screening Form dated 8/30/24, showed Resident 14 was receiving an altered diet - regular diet, mechanical soft texture. The form additionally showed Resident 14's diagnosis and clinical symptoms indicating presence of dysphagia (difficulty with swallowing) and was recommended to continue with the current diet.<br><br>32179<br><br>2. Medical record review of Resident 132 was initiated on 11/4/24. Resident 132 was admitted to the facility on [DATE].<br><br>On 11/6/24 at 0815 hours, Resident 132 was observed eating her breakfast tray. Resident 132 finished almost 50% of the food and stated they served cereal but no milk and no coffee. Resident 132's diet card showed to provide 4 ounces of low fat milk and black coffee.<br><br>On 11/6/24 at 0840 hours, CNA 4 was summoned to the room. CNA 4 stated she did not know who provided the breakfast tray to Resident 132. CNA 4 acknowledged Resident 132 should have been provided milk and coffee. CNA 4 verified the findings. |

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| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide special eating equipment and utensils for residents who need them and appropriate assistance.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one nonsampled residents (Resident 53) was provided with an assistive eating device during mealtimes. This failure had the potential to impact Resident 53's nutritional status.<br><br>Findings:<br><br>Review of the facility's P&P titled Self-Feeding Devices dated 2023 showed it is the policy of the facility that residents will receive self-feeding devices to maintain or improve their ability to eat or drink independently. Residents needing devices will receive them with each meal or snack, on their meal trays. Tray cards and diet profile will record which device is needed.<br><br>On 11/4/24 at 1225 hours, a lunch observation was conducted in Resident 53's room. Resident 53 was observed feeding himself only using his right hand. Resident 53 was observed carefully scooping the food using regular utensils. There were no adaptive devices observed. Review of Resident 53's meal ticket failed to show the use of built-up utensils.<br><br>Medical record review for Resident 53 was initiated on 11/4/24. Resident 53 was admitted to the facility on [DATE].<br><br>Review of Resident 53's Order Summary Report dated active as of 11/4/24, showed Resident 53 had a physician's order dated 5/16/24, for built up utensils during all meals.<br><br>Review of Resident 53's Care Plan titled Occupational Therapy initiated 4/23/24, showed an intervention for built-up handles for all meals.<br><br>On 11/4/24 at 1230 hours, an observation and concurrent interview was conducted with RNA 1. RNA 1 verified Resident 53 had regular utensils.<br><br>On 11/6/24 at 1350 hours, an interview was conducted with the FSD. The FSD acknowledged and verified the above findings. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 47476<br><br>Based on observation, interview, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed when:<br><br>* The facility failed to ensure the expired food items in the kitchen were discarded. A bin containing thawed packages of mechanically separated turkey had a use-by date of [DATE], and a bin containing thawed chicken had a use-by date of [DATE], were seen in the kitchen refrigerator.<br><br>* The facility failed to ensure the kitchen utensils were clean, free of food particles, and not worn out.<br><br>These failures posed the risk for food borne illnesses in highly susceptible resident population of 132 facility residents who received food prepared in the kitchen.<br><br>Findings:<br><br>Review of the facility's document showed 132 of 141 residents received food prepared in the kitchen.<br><br>1. On [DATE] at 0757 hours, two bins containing thawed poultry were observed on the bottom shelf of the walk-in refrigerator. One bin contained packages of mechanically separated turkey was labeled with a thaw date of [DATE], and a use-by date of [DATE]. The other bin contained raw chicken and was labeled with a thaw date of [DATE], and a use by date of [DATE]. There was a metal sheet pan containing raw chicken stored on top of the bin containing the raw chicken. The metal sheet pan was covered with foil and labeled with the date of [DATE].<br><br>On [DATE] at 0804 hours, the FSD verified the above findings. The FSD stated she needed to throw out the chicken and the turkey was supposed to be used the day prior, but they did not use it and would need to throw it out.<br><br>2. According to the USDA Food Code 2022, Section ,d+[DATE].11, Multiuse, Characteristics, for materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition.<br><br>On [DATE] at 0813 hours, an observation and concurrent interview was conducted with the FSD. One melted and heavily used rubber spatula was observed stored in a drawer, one chipped rubber spatula was observed air-drying, and a melted handle of one metal spatula was observed stored in a drawer. The FSD verified the findings.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. According to the USDA Food Code 2022, ,d+[DATE].11 Equipment, Food- Contact Surfaces, Nonfood Contact Surface, and Utensils, the food- contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.<br><br>On [DATE] at 0813 hours, an observation and concurrent interview was conducted with the FSD. One ladle with brown residues was observed being stored in a drawer with other clean utensils. The FSD verified the findings. |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>47476<br><br>Based on observation, interview, and facility P&P review, the facility failed to ensure the P&P regarding outside food for residents was followed.<br><br>* The facility failed to ensure the facility staff responsible for handling food brought for the residents from the outside and family/visitors who brought food for residents from the outside were educated on safe food handling procedures. This failure posed the risk for food borne illness in residents who consume food from outside sources.<br><br>Findings:<br><br>Review of the facility's P&P titled Foods Brought by Family/Visitors revised 3/2022 showed the following:<br><br>- Family/visitors are asked to prepare and transport food using safe food handling practices, including safe cooling and reheating processes, holding temperatures, preventing cross-contamination with raw and undercooked foods, and hand hygiene.<br><br>- Safe food handling practices are explained to family/visitors in a language and format they understand.<br><br>On 11/6/24 at 1411 hours, an interview was conducted with CNA 2. CNA 2 was asked what her role was when the residents had food brought in from the outside. CNA 2 stated she would check with the nurse, and if they wanted to store it, she would date it and would let them know that they could only keep it for three days. CNA 2 stated if the food was hot, she would let it cool down before she put it in the refrigerator. CNA 2 stated to cool down the food, she would leave it if it was covered in a bag or loosen the container a little bit before she put it in the refrigerator, then would check on it before the end of her shift. CNA 2 further stated if the food was still warm, she would let the following CNA know about the food.<br><br>On 11/6/24 at 1436 hours, an interview was conducted with the FSD. The FSD stated she provided in-services to the kitchen staff regarding safe food handling and the DSD would give in-services to the floor staff regarding safe food handling.<br><br>On 11/6/24 at 1507 hours, 1614 hours, and 1619 hours, an interview was conducted with the DSD. The DSD stated he provided education to the staff regarding providing residents food during mealtimes. The DSD verified he did not give education to the staff or family/visitors regarding safe food handling when the residents have food brought in from the outside.<br><br>On 11/6/24 at 1624 hours, a follow-up interview was conducted with the FSD. The FSD verified the RD did not provide any education to the facility staff or residents' family/visitors for safe food handling practices.<br><br>(continued on next page) |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/7/24 at 1001 hours, the DON was informed of the above findings. The DON stated they encouraged the residents' family/visitors to bring food in from the outside as long as they were compliant with the therapeutic diets. The DON verified they did not provide the residents' visitors/family safe food handing education. |

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|---|---|---|---|
| | 555328 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Fountain Valley Post Acute | 11680 Warner Avenue<br>Fountain Valley, CA 92708 |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474<br><br>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the infection control was maintained as evidenced by:<br><br>* The facility failed to ensure Residents 34 and 743 with indwelling urinary catheters and midline IV (intravenous) catheter were placed on EBP as per the facility's P&P.<br><br>* The facility failed to conduct surveillance of infections for the residents who showed signs and symptoms of infection but were not on antimicrobials.<br><br>* The facility failed to identity organisms on the surveillance line listing.<br><br>* Resident 38's indwelling urinary catheter drainage bag was on the floor and a urinal with scant amount of yellow urine was observed hanging from the trash can adjacent to Resident 38's bed.<br><br>These failures put the residents a risk for increased risk of infection and transmissions of diseases.<br><br>Findings:<br><br>Review of the facility's P&P titled Enhanced Barrier Precautions revised 3/2024, showed the purpose of this policy is to ensure the safety of residents, healthcare workers, and visitors by implementing enhanced barrier precautions in situations where there is an increased risk of transmission of infectious diseases. The facility will communicate to staff which residents require the use of enhanced barrier precautions while helping maintain a home-like environment. PPE (personal protective equipment) supplies such as gowns and gloves may be placed near or outside the resident's rooms. Enhanced barrier precautions are indicated for residents with any of the following:<br><br>- wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO (Multidrug-resistant organisms - organisms that are resistant to multiple antibiotics or antifungals).<br><br>The P&P further showed to wear gowns and gloves while performing the following high-contact tasks associated with the greatest risk for MDRO contamination of staff hands, clothes, and the environment such as:<br><br>- device care, for example, urinary catheter, feeding tube, tracheostomy, vascular catheter.<br><br>- any care activity where close contact with he resident is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs, respiratory care.<br><br>- changing bed lines.<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 | Review of the facility P&P titled Surveillance for Infections revised 5/2024, showed the IP will conduct ongoing surveillance for healthcare-associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and HAIs, to guide appropriate interventions, and to prevent future infections. Infections that may be considered in surveillance include those with limited transmissibility in a healthcare environment; and/or limited prevention strategies. Infections that will be included in routine surveillance include those with pathogens associated with serious outbreaks. The P&P further showed nursing staff will monitor residents for sighs and symptoms that my suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the charge nurse as soon as possible. Moreover, the P&P showed the IP or designated infection control personnel is responsible for gathering and interpreting surveillance the data.<br><br>Review of the facility's P&P titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes revised 5/2024, showed antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include pathogen identified.<br><br>1.a. Medical record review for Resident 34 was initiated on 11/4/24. Resident 34 was admitted to the facility on [DATE].<br><br>Review of Resident 34's H&P examination dated 9/5/24, showed the resident had the capacity to understand and make decisions.<br><br>Review of Resident 34's Order Summary Report for November 2024 showed the following physician's orders:<br><br>- dated 9/2/24, for the indwelling catheter monitor for change in urine character.<br><br>- dated 9/2/24, for the indwelling urinary catheter bag to be in the privacy bag and catheter leg strap on at all times.<br><br>- dated 9/2/24, for the indwelling catheter 16 Fr/10 ml bulb monitor for placement, change PRN if leaked, clogged, dislodged.<br><br>Further review of Resident 34's order summary report showed no documented evidence there was an order for EBP.<br><br>On 11/5/24 at 0828 hours, during an observation, there was no evidence of EBP sign or PPE supplies in front of Resident 34's room.<br><br>On 11/5/24 at 0848 hours, an interview with Resident 34 was conducted in the resident's room. When asked if the licensed nurses or CNAs should wear PPE including gown and gloves when performing indwelling catheter care, Resident 34 replied, No, the staff do not.<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 | On 11/5/24 at 0910 hours, a concurrent interview and medical record review was conducted with LVN 1. LVN 1 verified Resident 34 had an indwelling catheter. LVN 1 stated the residents with indwelling catheters, GT, open wounds, or IV lines were expected to be on EBP. LVN 1 further stated the residents on EBP needed to have a sign indicating the resident was on EBP and should have PPE items such as gloves and gowns available outside the resident's room.<br><br>b. Medical record review for Resident 743 was initiated on 11/4/24. Resident 743 was admitted to the facility on [DATE].<br><br>Further review of Resident 743's Order Summary Report dated 11/5/24, showed the following physician orders:<br><br>- dated 10/27/24, may insert a midline for IV access stat.<br><br>- dated 10/27/24, to monitor IV site every shift for s/sx of infection (redness, swelling, warmth, pain) every shift.<br><br>- dated 10/27/24, to change PICC (peripherally inserted central catheter)/Midline Central (a thin, flexible tube inserted into a vein in the upper arm to deliver fluids or medication into the blood stream) dressing site, cleanse with PICC Dressing Kit with biopatch and waterproof transparent dressing every week on Sundays for IV therapy.<br><br>Further review of Resident 743's order summary report showed no documented evidence there was an order for EBP.<br><br>On 11/5/24 at 0942 hours, during an observation, CNA 6 entered Resident 743's room with clean linens, without wearing PPE. Further observation showed no sign for EBP or PPE supplies outside of Resident 743's room.<br><br>On 11/5/24 at 0956 hours, an interview was conducted with CNA 6. CNA 6 verified she changed Resident 743's bedsheets without wearing PPE. CNA 6 further verified there was no signs for EBP or PPE available outside of Resident 743's room. CNA 6 stated EBP was used to protect the staff and residents and to maintain infection control.<br><br>On 11/5/24 at 1015 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 verified Resident 743 had a midline to her right upper arm. LVN 4 stated the residents with midline catheter, PICC, GT, indwelling catheters, and immunocompromised should be placed on EBP and should have a care plan for the EBP. LVN 4 further stated Resident 743 was not on EBP; however, they should be. LVN 4 verified there was no physician's orders for EBP or sign at the resident's door indicating Resident 743 was on EBP.<br><br>On 11/6/24 at 0829 hours, an interview was conducted with the IP. The IP stated the residents with indwelling catheters, wounds, GT, PICC and midline catheters were expected to be placed on EBP. The IP stated she expected the staff entering rooms with EBP to wear the proper PPE including gown and gloves. The IP verified Residents 34 and 743 should have been on EBP. The IP further stated EBP would ensure the infection control was maintained and help to eliminate the spread of infection.<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 | On 11/7/24 at 1400 hours, an interview was conducted with the Administrator, DON, and Regional Quality Assurance Nurse present. The DON stated the residents with devices, wounds, PICC or midlines, indwelling catheters, and GT were placed on EBP for infection control. The Administrator, DON, and Regional Quality Assurance Nurse acknowledged the above findings for Residents 34 and 743.<br><br>2. Review of the facility document titled Monthly Infection Surveillance Report for September 2024 showed 31 residents were prescribed antibiotics.<br><br>On 11/6/24 at 0858 hours, an interview and concurrent facility document review was conducted with the IP. The IP verified the residents with s/sx of infection who were not prescribed antimicrobials were not listed on the surveillance report. When the IP was asked if the residents who showed s/sx of infections and not placed on the surveillance report met the criteria for a true infection, the IP stated she would not know if the residents would meet the criteria for a true infection since she did not include the residents on the surveillance report. The IP stated she should include the residents with s/sx on the surveillance report to ensure the residents were being tracked and monitored.<br><br>3. Review of the facility document titled Monthly Infection Surveillance Report for September 2024 and Monthly Infection Surveillance Report October 2024 showed no documented evidence the report included the organism or pathogen involved in the infection for all the residents on the report as per the facility's P&P.<br><br>On 11/6/24 at 0846 hours, a concurrent interview and facility document review was conducted with the IP. The IP verified the Monthly Infection Surveillance Report for September and October 2024 did not include the organism or pathogen for all the residents prescribed antimicrobials and on the surveillance report. The IP stated the purpose of identifying and including the organism or pathogen was to ensure the facility would be able to identify a pattern or cluster and treat. The IP further stated identifying the organism or pathogen would help eliminate the overuse of antimicrobials and should be included.<br><br>On 11/7/24 at 1400 hours, an interview was conducted with the Administrator, DON, and Regional Quality Assurance Nurse present. The DON stated the facility should monitor the s/sx of infection from the beginning and included the residents on the surveillance to monitor if there was a trend of infections occurring in the facility. The Administrator, DON, and Regional Quality Assurance Nurse acknowledged the above findings.<br><br>46787<br><br>4. On 11/4/24 at 1200 hours, the following observations were made in Resident 38's room:<br><br>- Resident 38's indwelling urinary catheter drainage bag was on the floor and<br><br>- a urinal with scant amount of yellow urine was observed hanging from the trash can adjacent to Resident 38's bed.<br><br>On 11/4/24 at 1205 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 acknowledged and verified the above findings.<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 | Medical record review for Resident 38 was initiated on 11/4/24. Resident 38 was admitted to the facility on [DATE].<br><br>Review of Resident 38's H&P examination undated showed Resident 83 had the capacity to understand and make decisions.<br><br>Review of Resident 38's Order Summary Report dated 11/4/24, showed a physician's order dated 6/7/24, for an indwelling urinary catheter for wound management.<br><br>On 11/7/24 at 1430 hours, an interview was conducted with the DON. The DON acknowledged the above findings. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure six of six final sampled residents (Residents 38, 60, 76, 443, 596, and 743) reviewed for pneumococcal vaccinations were educated and offered the pneumococcal vaccination as evidenced by:<br><br>* The facility failed to offer the educational materials of the risks and benefits for the pneumococcal vaccines to Residents 60, 76, 443, 596, and 743 as per the facility's P&P.<br><br>* The facility failed to offer Resident 38's responsible party the PPSV 23 (pneumococcal polysaccharide vaccine) vaccine.<br><br>These failures put the residents at risk for infection and transmission of pneumococcal infections.<br><br>Findings:<br><br>Review of the facility's P&P titled Pneumococcal Vaccine revised on 3/2024 showed all residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. Further review of the P&P showed before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. The provision of such education is documented in the resident's medical record.<br><br>1. Medical record review for Resident 60 was initiated on 11/4/24. Resident 60 was admitted to the facility on [DATE].<br><br>Review of Resident 60's medical record failed to show the educational materials of the risks and benefits for the pneumococcal vaccine was offered to the resident.<br><br>2. Medical record review for Resident 76 was initiated on 11/4/24. Resident 76 was admitted to the facility on [DATE], and readmitted to the facility on [DATE].<br><br>Review of Resident 76's medical record failed to show the educational materials of the risks and benefits for the pneumococcal vaccine was offered to the resident.<br><br>3. Medical record review for Resident 443 was initiated on 11/4/24. Resident 443 was admitted to the facility on [DATE].<br><br>Review of Resident 443's medical record failed to show the educational materials of the risks and benefits for the pneumococcal vaccine was offered to the resident.<br><br>4. Medical record review for Resident 596 was initiated on 11/4/24. Resident 596 was admitted to the facility on [DATE].<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 596's medical record failed to show the educational materials of the risks and benefits for the pneumococcal vaccine was offered to the resident.<br><br>5. Medical record review for Resident 743 was initiated on 11/4/24. Resident 743 was admitted to the facility on [DATE].<br><br>Review of Resident 743's medical record failed to show the educational materials of the risks and benefits for the pneumococcal vaccine was offered to the resident.<br><br>On 11/6/24 at 0815 hours, an interview and concurrent medical record review for Residents 60, 76, 443, 596, and 743 were conducted with the IP. The IP verified the educational materials of the risk and benefits of the pneumococcal vaccine were not provided to the residents. The IP stated the education material, Vaccine Information Statement (VIS) for pneumococcal should have been provided to the residents. The IP further stated the VIS for pneumococcal provided the residents information about the vaccine in written format that had been addressed verbally and provided the residents more information of the risks and benefits, possible reactions of the vaccine, and the treatments.<br><br>On 11/7/24 at 1400 hours, an interview was conducted with the Administrator, DON, and Regional Quality Assurance Nurse. The DON stated the VIS handout provided the residents more information and explanation about the vaccine and the facility would be providing the VIS for the pneumococcal vaccine to the residents. The Administrator, DON, and Regional Quality Assurance Nurse acknowledged the above findings.<br><br>46787<br><br>6. Medical record review for Resident 38 was initiated on 11/4/24. Resident 38 was admitted to the facility on [DATE].<br><br>Review of Resident 38's H&P examination undated showed Resident 83 had the capacity to understand and make decisions.<br><br>Review of Resident 38's immunization record showed the pneumococcal vaccine PCV13 was administered on 1/13/21.<br><br>Further review of Resident 38's medical record failed to show evidence Resident 38's responsible party was offered the PPSV 23 vaccine after receiving the PCV 13 as per the CDC's guidelines.<br><br>On 11/7/24 at 0800 hours, an interview and concurrent medical record review was conducted with the IP. The IP acknowledged and verified the above findings. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure six of six final sampled residents (Residents 38, 60, 76, 443, 596, and 743) reviewed for COVID-19 vaccinations were educated and offered the COVID-19 vaccination as evidenced by:<br><br>* The facility failed to offer the educational materials of the risks and benefits for the COVID-19 vaccines to Residents 60, 76, 443, 596, and 743 as per the facility's P&P.<br><br>* The facility failed to offer Resident 38's responsible party the seasonal COVID-19 vaccine.<br><br>These failures put the residents at risk for increased risk of infection and transmission of COVID-19.<br><br>Findings:<br><br>Review of the facility's P&P titled Coronavirus Disease (COVID-19) - Vaccination of Residents revised on 11/2024 showed each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated. Residents who are eligible to receive the COVID-19 vaccine are strongly encouraged to do so. COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist and coordinated by his or her designee. The P&P further showed before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risk, and potential side effects associated with the vaccine. The information is provided to the resident in a format and language that is understood by the resident or representative. Moreover, the P&P further showed the resident's medical record includes documentation that indicates, at a minimum, the following:<br><br>a. That the resident or resident representative was provided education regarding the benefits and potential risk associated with COVID-19 vaccine, including:<br><br>- samples of the educational materials used;<br><br>- the date the education took place; and<br><br>- the name of the individual who received the education.<br><br>1. Medical record review for Resident 60 was initiated on 11/4/24. Resident 60 was admitted to the facility on [DATE].<br><br>Review of Resident 60's medical record failed to show the educational materials of the risk and benefits for the COVID-19 vaccine were offered to the resident.<br><br>2. Medical record review for Resident 76 was initiated on 11/4/24. Resident 76 was admitted to the facility on [DATE] and readmitted back to the facility on [DATE].<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 76's medical record failed to show the educational materials of the risk and benefits for the COVID-19 vaccine were offered to the resident.<br><br>3. Medical record review for Resident 443 was initiated on 11/4/24. Resident 443 was admitted to the facility on [DATE].<br><br>Review of Resident 443's medical record failed to show the educational materials of the risk and benefits for the COVID-19 vaccine were offered to the resident.<br><br>4. Medical record review for Resident 596 was initiated on 11/4/24. Resident 596 was admitted to the facility on [DATE].<br><br>Review of Resident 596's medical record failed to show the educational materials of the risk and benefits for the COVID-19 vaccine were offered to the resident.<br><br>5. Medical record review for Resident 743 was initiated on 11/4/24. Resident 743 was admitted to the facility on [DATE].<br><br>Review of Resident 743's medical record failed to show the educational materials of the risk and benefits for the COVID-19 vaccine were offered to the resident.<br><br>On 11/6/24 at 0815 hours, an interview and concurrent medical record review for Residents 60, 76, 443, 596, and 743 were conducted with the IP. The IP verified theeducational materials of the risk and benefits of the COVID-19 vaccine were not provided to the residents. The IP stated the education material called the Vaccine Information Statement (VIS) for COVID-19 should have been provided to the residents. The IP further stated the VIS for COVID-19 provided the residents information about the vaccine in written format that had been addressed verbally and provided the residents more information of the risk and benefits, possible reactions to the vaccine, and the treatments.<br><br>On 11/7/24 at 1400 hours, an interview was conducted with the Administrator, DON, and Regional Quality Assurance Nurse. The DON stated the VIS handout provided the residents more information and explanation about the vaccine and the facility would be providing the VIS for the COVID-19 vaccine to the residents. The Administrator, DON, and Regional Quality Assurance Nurse acknowledged the above findings.<br><br>46787<br><br>6. Medical record review for Resident 38 was initiated on 11/4/24. Resident 38 was admitted to the facility on [DATE].<br><br>Review of Resident 38's H&P examination undated showed Resident 38 had the capacity to understand and make decisions.<br><br>Review of Resident 38's immunization record showed the previous COVID-19 vaccine was administered on 6/21/22.<br><br>Further review of Resident 38's medical record failed to show evidence Resident 38's responsible party was offered the seasonal COVID-19 vaccine.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/7/24 at 0800 hours, an interview and concurrent medical record review was conducted with the IP. The IP acknowledged and verified the above findings. |