| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555476 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Apple Valley Care Center | 11959 Apple Valley Road<br>Apple Valley, CA 92308 |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>29673<br><br>Based on interview, document review, and facility policy review, the facility failed to resolve grievances voiced by 5 (Residents #20, #36, #66, #195, and #200) of 5 residents who attended the resident council meeting.<br><br>Findings included:<br><br>A facility policy titled, Grievances/Complaints, Filing, revised 04/2017, revealed, Residents and their representative have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative.<br><br>During the resident council meeting on 10/15/2024 at 1:32 PM, the residents in attendance stated the facility did not always follow-up on their grievances. The residents stated they had voiced grievances related to the noise at night in the hall and staff respond their call light and state they would be back, but never return. The residents stated they have spoken to the facility about their concerns, things get better, but due to the high staff turnover, things revert back. The residents stated the Activity Director (AD) was the person that reported their concerns to.<br><br>During an interview on 10/17/2024 at 10:56 AM, the AD stated resident concerns voiced during the Resident Council meeting were not considered grievances. The AD stated if the concerns were not addressed, they were discussed in the next resident council meeting.<br><br>The Resident Council Minutes for the timeframe May 2024 through October 2024, revealed call lights not being answered and/or the call light turned off without staff returning to provide services were listed as concerns from May 2024 to October 2024. |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>45849<br><br>Based on record review, document review, and interview, the facility failed to ensure the discharge Minimum Data Set (MDS) was accurate for the location of disposition at the time of discharge for 1 (Resident #91) of 18 sampled residents.<br><br>Findings included:<br><br>The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, dated 10/2024, revealed The RAI process has multiple regulatory requirements. Federal regulation at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status. The User's Manual specified, Knowing the setting to which the individual was discharged helps to inform discharge planning.<br><br>An Admission Record revealed the facility admitted Resident #91 on 07/16/2024. According to the Admission Record, Resident #91 discharged home on 07/30/2024.<br><br>A discharge MDS, with an Assessment Reference Date (ARD) of 07/30/2024 indicated Resident #91 discharged to a short-term general hospital.<br><br>Resident #91's care plan, included a focus area initiated 06/21/2024, that indicated the resident wished to discharge to home when their therapy goals were met.<br><br>Resident #91's physician orders revealed an order with a revision date of 07/29/2024, that indicated the resident would discharge home with family on 07/3/2024.<br><br>In an interview on 10/17/2024 at 8:51 AM, the MDS Coordinator stated the information on Resident #91's discharge MDS was incorrect.<br><br>In an interview on 10/17/2024 at 11:29 AM, the Director of Nursing (DON) stated her expectation was that the MDS should be completed timely and correctly. The DON stated the facility did not have a policy for MDS completion but followed the RAI guidelines.<br><br>In an interview on 10/17/2024 at 11:39 AM, the Administrator stated she expected the MDS to be correct. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>45849<br><br>Based on interview, record review, document review, and facility policy review, the facility failed to notify the physician of pharmacy recommendations and failed to ensure the facility policy indicated a time frame for the physician response to pharmacy recommendations for 2 (Resident #40 and Resident #85) of 5 sampled residents reviewed for unnecessary medications.<br><br>Findings included:<br><br>A facility policy titled, Medication Regimen Reviews, revised 05/2019, indicated, Policy Statement The consultant pharmacist reviews the medication regimen of each resident at least monthly. The policy specified, 4. The goal of the MRR [medication regimen review] is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medications. The policy indicated, 11. If the physician does not provide a timely or adequate response, or the consultant pharmacist identified that no action has been taken, he/she contacts the medical director or (if the medical director is the physician of record) the administrator. 12. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it. The policy did not indicate a time frame for the physician response.<br><br>1. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/01/2024, revealed the facility admitted Resident #40 on 09/07/2023. The MDS revealed the resident had active diagnoses to include arthritis, cervical disc degeneration, disorders of bone density and structure, and chronic pain syndrome. Per the MDS, the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #40 took an opioid medication.<br><br>Resident #40's Order Summary Report, that contained active orders as of 10/16/2024, revealed an order dated 08/20/2024, for Morphine Sulfate (concentrate) solution 20 milligrams per milliliter (mg/ml), give 0.5 ml by mouth every four hours for pain management.<br><br>The facility medication regimen review report dated 10/04/2024, revealed a recommendation that directed the staff to call the physician now and write an order to clarify the dose of morphine sulfate that should be administered to the resident.<br><br>In an interview on 10/17/2024 at 11:29 AM, the Director of Nursing (DON) stated the morphine order was still incorrect and had not been clarified. The DON stated she forgot to follow up because the pharmacist discussed the recommendation with the charge nurse, but the DON did not know which charge nurse it was. The DON stated she expected the physician to be notified within 48 hours of a pharmacy recommendation. The DON stated if the recommendation was not followed up on, there could be an adverse reaction.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/15/2024, revealed the facility admitted Resident #85 on 08/09/2024. The MDS revealed the resident had active diagnoses to include Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, and encounter for palliative care. Per the MDS, the resident had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment.<br><br>Resident #85's Order Summary Report, that contained active orders as of 10/16/2024, revealed an order dated 09/12/2024, for lorazepam intensol oral concentrate 2 milligram (mg) per milliliter (ml), give 0.5 ml by mouth every six hours as needed for anxiety manifested by agitation /restlessness and an order dated 09/19/2024, for ABHR (a topical gel that contained four drugs: lorazepam, diphenhydramine, haloperidol, and metoclopramide that was used to treat nausea and vomiting and to subdue agitated residents) cream/gel apply 1 ml to inner wrist every six hours as needed for anxiety/agitation.<br><br>The facility medication regimen review report dated 08/12/2024, revealed a recommendation for Resident #85 that indicated agitation, unspecified, or restlessness were not sufficient reasons for the use an antipsychotic medication and to limit the as needed Ativan (lorazepam) to 14 days.<br><br>The facility medication regimen review report dated 10/04/2024, revealed a recommendation for Resident #85 that indicated agitation, unspecified, or restlessness were not sufficient reasons for the use an antipsychotic medication and to discontinue the as needed ABHR today because as needed antipsychotics were not appropriate in this setting.<br><br>In an interview on 10/17/2024 at 9:36 AM, the Director of Nursing (DON) stated Resident #85 was on the PRN medications because the resident was on hospice services. The DON stated she spoke to the hospice nurse about the pharmacist's recommendations, who then spoke to the hospice physician; however, there was no documentation of the physician notification.<br><br>In an interview on 10/17/2024 at 10:31 AM, the Consultant Pharmacist stated his expectation was that his recommendations would be followed up on within two weeks.<br><br>In a follow-up interview on 10/17/2024 at 11:29 AM, the DON stated her expectation was that the medication regimen review recommendations should be followed up on within one week.<br><br>The DON stated if the physician was not notified there could be an adverse reaction.<br><br>In an interview on 10/17/2024 at 11:39 AM, the Administrator stated she expected the physician to be notified of any pharmacy recommendations. |

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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>36105<br><br>Based on observation, record review, interview, and facility policy review, the facility failed to ensure the medication error rate was not greater than 5 percent (%). The facility had 2 medication errors out of 31 total opportunities, which resulted in a medication error rate of 6.45% (percent) for 2 (Resident #23 and Resident #66) of 7 residents observed for medication administration.<br><br>Findings included:<br><br>A facility policy titled, Administering Medications, revised 04/2019, specified, Medications are administered in a safe and timely manner, and as prescribed. The policy specified, 10. The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.<br><br>1.An Admission Record indicated the facility admitted Resident #66 on 07/01//2024. According to the Admission Record, the resident had a medical history that included a diagnosis of generalized muscle weakness.<br><br>Resident #66's Order Summary Report revealed a physician's order dated 07/02/2024, for a multiple vitamin tablet to be given one time per day as a supplement.<br><br>During an observation of medication administration on 10/15/2024 at 9:17 AM, Licensed Vocational Nurse (LVN) #6 administered one multivitamin with minerals tablet to Resident #66.<br><br>During an interview on 10/15/2024 at 11:20 AM, LVN #6 stated she gave a multivitamin with minerals to Resident # 66, but she gave the wrong one because the physician's order was for a multivitamin with no minerals.<br><br>During an interview on 10/15/2024 at 11:34 AM, the Director of Nursing stated the nurse should have read the label on the medication, followed the order, and gave the correct medication to Resident #66.<br><br>2. An Admission Record indicated the facility admitted Resident #23 on 11/13/2020. According to the Admission Record, the resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease.<br><br>Resident #23's Order Summary Report revealed a physician's order dated 01/19/2022, for a multiple vitamin with minerals tablet to be given one time per day as a supplement.<br><br>During an observation of medication administration on 10/15/2024 at 9:53 AM, Licensed Vocational Nurse (LVN) #7 administered one multivitamin tablet to Resident #23.<br><br>During an interview on 10/15/2024 at 11:16 AM, LVN #7 stated she did not give Resident #23 the multivitamin with minerals, but gave the resident the multivitamin. LVN #7 stated she gave the multivitamin without minerals, which was not ordered.<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 | During an interview on 10/15/2024 at 11:36 AM, the Director of Nursing stated the nurse should have followed the order and compared the medication label to the medication administration record before she administered the medication.<br><br>During an interview on 10/17/2024 at 11:18 AM, the Administrator stated the nurses should have read the label for both residents and compared it to what was ordered and gave the right medication as ordered. The Administrator stated if there was a question about the medication, the nurses should have stopped and called to double check the order with the doctor or asked the DON for direction. |