Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555609 | A. Building<br>B. Wing | 01/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Glendale Healthcare Center | 1208 S. Central Ave<br>Glendale, CA 91204 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51745<br><br>Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 19) had an informed consent (the voluntary agreement of a resident or a resident's representative to accept a treatment or procedure after receiving information regarding risks and benefits of the treatment) prior to treatment of Amitriptyline (a medication used to treat depression [severe feeling of sadness and hopelessness] and neuropathic [damaged nerves] pain in adults).<br><br>This failure violated the residents rights of Resident 19 or representative to make an informed decision about the treatments of Amitriptyline and its side effects such as increased agitation, irritability and worsened depression of the medication and any alternative treatments available.<br><br>Findings:<br><br>During a review of Resident 19's Admission Record (Face Sheet), dated 1/23/2025, the face sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including polyneuropathy (damage to many nerves throughout the body at the same time, causing symptoms like numbness, tingling, burning pain, and weakness) and pyogenic arthritis (a painful infection of a joint caused by bacteria). The face sheet indicated Resident 19 was self-responsible.<br><br>During a review of Resident 19's Minimum Data Set (MDS - a resident assessment tool), dated 12/28/2024, the MDS indicated the cognitive (the ability to think and process information) skills for daily decision making were moderately impaired. The MDS indicated the resident was taking a high-risk drug classified as an antidepressant (a type of medicine used to treat clinical depression [a mood disorder that causes a persistent feeling of sadness and loss of interest.]).<br><br>During a review of Resident 19's Order Summary Report, with an order date of 5/24/2024, the Order Summary Report indicated Resident 19 was ordered Amitriptyline oral (given by mouth) tablet 10 mg (milligrams-unit of measurement) 2 tablets by mouth at bedtime for neuropathic (nerve) pain.<br><br>During a review of Resident 19's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated January 2025, the MAR indicated the resident had received Amitriptyline each evening from 1/1/2025-1/22/2025.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 19's Care Plan titled, The Resident ' s Overall Condition Requires Long-Term Care, with a revision date of 12/6/2024, the care plan indicated an intervention of resident will be encouraged to make decisions regarding life in facility.<br><br>During a review of Resident 19's care plan titled, The Resident Uses Antidepressant Medication Amitriptyline Oral Tablet for Neuropathic Pain, with a revision date of 1/10/2025, the care plan indicated the resident/family/caregivers would be educated regarding the benefits, side effects, and toxic symptoms of the anti-depressant drug being given.<br><br>During a concurrent interview and record review on 1/23/2025 at 1:38 PM, Resident 19 ' s clinical record from 5/24/2024 to 1/23/2025 was reviewed with Licensed Vocational Nurse (LVN) 2, the clinical record indicated there was no documentation that Resident 19 or any responsible party received education regarding the risks and benefits of Amitriptyline prior to its initiation on 5/24/2024. There was no indication that the resident or responsible party consented to the use of amitriptyline. LVN 2 stated Resident 19 did not have an informed consent for amitriptyline prior to the start of administering amitriptyline. LVN 2 provided a document titled Facility Verification of Informed Consent dated 1/23/2025, the document stated that it was for the use of amitriptyline and that informed consent was obtained from Resident 19 on 1/23/2025.<br><br>During an interview and record review on 1/24/25 9:24 AM, the facility ' s policy and procedure (P&P) titled, Resident Rights, dated February 2021 was reviewed with Registered Nurse (RN) 1. The P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to self-determination and to be informed of and participate in his or her care planning and treatment. RN 1 stated that it was important to provide the resident with informed consent for psychotropic medication because it was a federal and state regulation and because the psychotropic medication can adversely affect the resident including behaviors and thoughts. RN 1 stated the facility should respect the patient ' s rights and inform them of their care.<br><br>During a review of the facility ' s P&P titled, Psychotropic Medication Use, dated July 2022, the P& P indicated, When determining whether to initiate, modify, or discontinue medication therapy .The evaluation will attempt to clarify whether: the actual or intended benefit of the medication is understood by the resident/representative. The P&P also indicated, Residents (and/or representatives) have the right to decline treatment with psychotropic medications. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. |

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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** 51745<br><br>Based on observation, interview, and record review, the facility failed to ensure two of eight sampled residents (Residents 15 and 195) had a call light device (a device used to call for assistance) within reach.<br><br>This failure had the potential to result in Residents 15 and 195 being unable to call for assistance when needed and not receive immediate care in the an emergency that could lead to falls, accidents and injury.<br><br>Findings:<br><br>a. During a review of Resident 15 ' s Admission Record (Face Sheet) dated 1/23/2025 , the face sheet indicated the facility admitted Resident 15 on 11/20/2019 with diagnoses including rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of left knee, and tear of meniscus (crescent shaped bands of thick, rubbery cartilage attached to the shinbone that act as shock absorbers and stabilize the knee) of the left knee.<br><br>During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool) dated 11/26/2024, the MDS indicated the cognitive (the ability to think and process information) skills for daily decision making were severely impaired, and the resident required substantial/maximal assistance (helper does more than half the effort) with toileting, oral hygiene, showering, personal hygiene, and lower body dressing. The MDS indicated the Resident was always incontinent (the involuntary loss of bladder or bowel control) and at risk for falls.<br><br>During an observation on 1/21/2025 at 10:03 AM in Resident 15's room, the resident was observed sitting up in bed. The call light for Resident 15 was observed on the floor beneath the bed.<br><br>During an interview on 1/21/2025 at 10:05 AM with Certified Nurse Assistant (CNA) 1 in Resident 15's room, CNA 1 stated the call light for Resident 15 was out of reach of the resident and should be within reach of the resident so the resident could call for help if needed. CNA 1 stated the resident could possibly fall out of bed and hurt themselves if the call light was out of reach.<br><br>During a review of Resident 15's Care Plan titled Alteration in Musculoskeletal Status Related to Contracture of Left Knee, with an initiation date of 5/17/2021, the care plan indicated an intervention of Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance.<br><br>b. During a review of Resident 195's Face Sheet dated 1/23/2025, the face sheet indicated the facility admitted Resident 195 on 6/26/2023 with a readmitted [DATE] with diagnoses including a history of falling, muscle weakness, dementia (a progressive state of decline in mental abilities), and rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints resulting in painful deformity and immobility).<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 195's MDS dated [DATE], the MDS indicated the cognitive skills for daily decision making were severely impaired, and the resident required partial/moderate assistance (Helper does less than half the effort) with toileting and oral hygiene. The MDS indicated Resident 195 was at risk for falls.<br><br>During an observation on 1/21/2025 at 10:19 AM in Resident 195's room, the resident was observed lying in bed with eyes closed. The call light for Resident 195 was observed on the floor beside the left side of the resident ' s bed.<br><br>During an interview on 1/21/2025 at 10:25 AM with CNA 2 in Resident 195's room, CNA 2 stated the call light was out of reach for Resident 195 and the Resident could be injured if trying to get out of bed on their own.<br><br>During a review of Resident 195's Care Plan titled May Put Bed in a Lower Position due to High Risk for Falls, with an initiation date of 12/20/2024, the care plan indicated an intervention of Attend to needs promptly.<br><br>During an interview on 1/23/2025 at 10:10 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated it was important for residents to have the call light within reach so the resident can call for help when needed and to prevent the resident from falling and being injured.<br><br>During a concurrent interview and record review on 1/23/2025 at 9:04 AM with the Registered Nurse (RN) 1, the facility ' s policy and procedure (P&P) titled, Call Light Policy, dated January 2024 was reviewed. RN 1 stated the P&P indicated, the call light should be within reach of the resident and answered in a timely manner. RN 1 stated that when the call light is out of reach and the residents need assistance we won ' t know and be able to attend to them right away, a resident might fall and injure themselves if trying to get out of bed on their own. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>48219<br><br>Based on interview and record review, the facility failed to notify the primary physician of the signitficant change of condition for 1 of 3 sampled residents (Resident 31) who had daily episodes of vomiting for unknown period of time.<br><br>This deficient practice resulted in the resident's delay in treatment and monitoring to prevent fluid loss, discomfort and weight loss.<br><br>Findings:<br><br>A review of Resident 31's Admission Record indicated the facility admitted the resident on 8/27/2021, with diagnoses that included Gastro- esophageal reflux disease (Acid reflux, a condition where stomach acid flows back up into the esophagus), intervertebral disc degeneration (spine loses ability to cushion the vertebrae) and kidney disease.<br><br>A review of Resident 31's Minimum Data Set (MDS- A comprehensive assessment and screening tool) Dated 12/1/2024, indicated Resident 31 had severely impaired cognition (a mental process that take place in in the brain, including thinking, attention, language, learning, memory, and perception) and required maximal assistance with activities of daily living.<br><br>During a concurrent interview and record review on 1/23/25 at 1:34 PM with Registered Nurse 2 (RN2), Resident 31's Progress notes dated from 12/23/24 - 1/20/25 was reviewed and indicated no documentation had been done for Resident 31's daily regurgitation (vomiting). Additionally, RN 2 stated there was no documentation in progress notes regarding daily vomiting or how long the resident had been having episodes of vomiting. RN 2 also stated there was no documented evidence that the primary physician was notified of Resident 31's episodes of vomiting.<br><br>During a concurrent observation and interview on 1/21/2025 at 11:22AM with Licensed Vocational Nurse (LVN) 3, in Resident 31's room, Resident 31 had bucket on ground next to bed. LVN 3 stated, she (Resident 31) has daily episodes of vomiting and uses the bucket when vomiting.<br><br>During an interview on 1/23/25 at 1:34 PM, with Registered Nurse (RN)1, RN1 stated the staff should be documenting how often and how many times Resident 31 was vomiting or regurgitating her food or liquids and the primary physician should be notified if the resident was vomiting.<br><br>A review of the facility ' s policy and procedure titled Change in a resident ' s condition or Status, Revised on 02/2021, indicated our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident ' s medical/ mental condition and /or status (changes in level of care). |

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854

Based on interview and record review, the facility failed to develop a resident specific comprehensive care plan that reflected the resident's current needs and health status for two out of eight sampled residents (Residents 6 and 39) by failing to ensure:

1. Resident 6's care plan for her weight loss had no measurable objectives and time frames such as the target weights for the resident.

2. Resident 39 did not have a care plan to address the care and monitoring of the resident ' s intravenous (IV- a thin, flexible tube that is inserted into a vein) insertion site.

This deficient practice placed Resident 6 at risk for further weight loss. For Resident 39, the resident had the potential to be at risk of complications associated with IV insertion such as bleeding, infiltration (leakage of fluid from the vein to the surrounding tissue causing pain and swollenness) and infection.

Findings:

1. A review of Resident 6's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included neck fracture (broken bone in the neck), history of falling, and malnutrition (lack of proper nutrition).

A review of Resident 6 ' s History and Physical (H&P), dated 9/10/2024, indicated the resident has the capacity to make her needs known, but does not have the capacity to make medical decisions. The H&P also indicated the resident has poor appetite.

A review of Resident 6's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/20/2024, indicated the resident has severely impaired cognition (ability to reason and thought process). The MDS also indicated the resident requires setup or clean-up assistance (helper sets up or cleans up) with eating.

A record review of the Resident 6 ' s care plans included an entry for Resident 6 ' s weight loss, initiated on 10/16/2025, and revised on 1/22/2025. indicated Resident 6' s weight will return to baseline range between [blank] and [blank] lbs (pounds, a unit of measuring weight) by review date. The care plan did not provide documented evidence of Resident 6's baseline weight.

During a concurrent interview and record review on 1/24/2025 at 9:31 AM with Registered Nurse (RN) 1, Resident 6 ' s care plan for weight loss was reviewed. RN 1 stated Resident 6 ' s care plan was incomplete because the goal of the care plan does not specify the target weight and had no measurable objectives and time frames such as weights.

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 1/25/2025 at 9:32 AM with RN 1, the facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, was reviewed. RN 1 stated the P&P indicated the care plan must include measurable objectives and time frames, such as weights.<br><br>2. A review of Resident 39's Admission Record indicated the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included surgical amputation (surgical removal of a body part), diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and osteomyelitis (inflammation of bone or bone marrow, usually due to infection).<br><br>A review of Resident 39's H&P, dated 12/29/2024, indicated the resident has the capacity to understand and make decisions.<br><br>A review of Resident 39's MDS, dated [DATE], indicated the resident has intact cognition.<br><br>A review of Resident 39's Order Summary Report, dated 1/24/2025, included an order for the following:<br><br>Meropenem [an antibiotic, a medication that treats infections] to administer via Intravenous Solution Reconstituted [medication in powder form mixed with a liquid solution] 1GM [GM, gram, a unit of measuring weight] Use 1 gram intravenously every 12 hours, ordered on 12/28/2024.<br><br>A review of Resident 39's care plans did not have documented evidence for a care plan to address the monitoring and care for Resident 39 ' s IV catheter.<br><br>During a concurrent observation and interview on 1/21/2025 at 9:22 AM, Resident 39 was observed lying in bed with an IV catheter (a small plastic tube inserted into the vein) on the right hand. Resident 39 stated the nurses use the IV catheter to administer medications.<br><br>During a concurrent observation and interview on 1/21/2025 at 9:43 AM inside Resident 39 ' s room, RN 1 stated Resident 39 has an IV catheter on the right hand.<br><br>During a concurrent interview and record review on 1/24/2025 at 9:29 AM with RN 1, Resident 39 ' s care plans were reviewed. RN 1 stated there was no care plan for Resident 39 ' s to address the care and monitoring for the IV catheter insertion site. RN 1 stated there should be a care plan for the IV catheter insertion site, because without it, staff would not know how to take care of the resident ' s IV catheter.<br><br>During an interview and concurrent interview on 1/24/2025 at 9:32 AM with RN 1, the facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, was reviewed. RN 1 stated the P&P indicated care plans must have measurable goals, such as a resident ' s weight. RN 1 also stated the P&P must reflect the resident ' s current condition, such as having a care plan for a resident ' s IV catheter.<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 | During a review of the facility ' s P&P titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated the comprehensive, person-centered care plan includes measurable objectives and timeframes. The P&P indicated the care plan includes the resident ' s goals and desired outcomes. The P&P also indicated care plans are revised as information about the residents and the residents ' conditions change. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>48219<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled residents (Resident 28) was provided care and services to maintain good grooming and personal hygiene by ensuring the resident's nail was free of dirt.<br><br>This deficient practice had potential to lead to skin infection and poor body image from having dirt underneath nails.<br><br>Findings:<br><br>A review of Resident 28's Admission record indicated the facility admitted the resident on 9/8/2020, with diagnosis that included malignant neoplasm of brain (fast growing Brain Tumor), acute respiratory failure (sudden condition that makes it difficult to breathe on your own), paralysis of vocal cords and larynx (unable to speak, swallow, or breath on own).<br><br>A review of Resident 28's History and Physical (H&P), undated, indicated the resident was alert and oriented to person, place, time.<br><br>A review of Resident 28's Minimum Data Sheet ( MDS, a standard assessment tool that measures health status), dated 12/14/2024, indicated the resident ' s cognition ( a mental process related to thinking, attention, language, learning, memory, and perception) was intact ( able to understand information, remember it, use it to make decisions, and effectively communicate those decisions). The MDS indicated Resident 28 needed partial /moderate assistance for upper body dressing and requires Substantial/ maximal assistance for personal hygiene tasks.<br><br>A review of Resident 28's Care Plan Resident prefers to have long nails initiated on 7/14/2021 with a revision date of 1/10/2025, the Care Plan indicated, Activities Department will observe that nails are maintained and cleaned at least 1x a week.<br><br>During a concurrent observation and interview on 1/21/2025 at 11:52AM with Licensed Vocational Nurse (LVN3) in Resident 28 ' s room. LVN 3 stated Resident 28 has dirt under nails.<br><br>During a review of the facility's policy and procedure (P&P) titled, Fingernails/ Toenails, Care of, with a revised date of February 2018, the P&P indicated nail care includes daily cleaning and regular trimming. Further stating proper nail care can aid in the prevention of skin problems. Indicating dirt under nails should be wiped away and removed from each nail to prevent infections. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>48219<br><br>Based on observation, interview, and record review, the facility failed to assess, monitor, intervene and evaluate care of two out of three sampled residents (Residents 28 and 31) by failing to:<br><br>1.Ensure Resident 28's wound on the left eye was identified and assessed by facility to ensure resident received timely and appropriate care for behavior of self -inflicted wound and scratching under the left eye.<br><br>2. Ensure Resident 31's daily episodes of emesis (vomit) where documented, assessed for the root cause, monitored and reported to the primary physician.<br><br>As a result of these deficient practices, Resident 28 could develop worsened skin and wound infection and severe pain. For Resident 31 frequent vomiting could result in dehydration (significant fluid loss in the body) and electrolytes (essential minerals in the body for the cells to function) loss that leads to and organ failures.<br><br>Findings:<br><br>1. A review of Resident 31's Admission Record indicated the facility admitted the resident on 8/27/2021, with diagnoses that included gastro- esophageal reflux disease (Acid reflux, a condition where stomach acid flows back up into the esophagus), intervertebral disc degeneration (spine loses ability to cushion the vertebrae) and kidney disease.<br><br>A review of Resident 31 ' s Minimum Data Set (MDS- A comprehensive assessment and screening tool) Dated 12/1/2024, indicated Resident 31 had severely impaired cognition (a mental process that take place in in the brain, including thinking, attention, language, learning, memory, and perception) and required maximal assistance, helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort with activities of daily living.<br><br>A review of Resident 28's Admission Record indicated the facility admitted the resident on 9/08/202, with diagnoses that included obstructive pulmonary disease (damage to the lungs that limits airflow into and out of the lungs) and malignant neoplasm of brain (cancerous brain tumor).<br><br>A review of Resident 28's History and physical, undated, indicated the resident is alert and oriented to person, place, time.<br><br>A review of Resident 28's Order Summary Report, and clinical records indicated no evidence that the resident was monitored for mood/ behavior for self-infliction or scratching of the left eye.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555609 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/24/2025 |
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| NAME OF PROVIDER OR SUPPLIER Glendale Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1208 S. Central Ave Glendale, CA 91204 | |

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

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident 28's care plan, dated 11/19/ 2024, indicated Resident 28 ' s had an actual unavoidable non healing impairment to skin integrity related to new left lower periorbital area self - inflicted scratch with Goal the resident will be free from complications new left lower periorbital area self - inflicted scratch. Interventions of Medication and/ or treatment as order by the physician, to monitor for side effects of the prescription and OTC (over the counter) drugs which could exacerbate the skin condition, and to report continued worsening of site, Signs and symptoms of infection and other signification issues to physician. T<br><br>A review of Resident 28's care plan dated 11/19/ 2024 did not indicate the root cause of the resident's behavior of left lower periorbital area self - inflicted scratch and interventions to address the resident's behavior to prevent self - inflicted scratching.<br><br>A review of Resident 28's Medication Administration Record indicated no monitoring for anxiety mood / behavior of self-infliction.<br><br>During an observation on 1/21/2025 at 11:42 AM, Resident 28 had a left lower eye redness, with active bleeding and open tear visible. In a concurrent interview Resident 28 stated the wound/tear under her eye had been there for 4 days and no treatment had been provided.<br><br>During an interview on 1/21/2025 at 11:52AM, with Licensed Vocational Nurse (LVN) 3, LVN 3 stated there was no change in condition report documented and no treatment being provided that was ordered by the physician regarding Resident 28 ' s under the eye wound. LVN 3 stated the physician was not notified of Resident 28 ' s behavior of self -inflicted wound due to scratching on the left eye.<br><br>During an interview on 1/21/2025 at 12:17 PM, with Licensed Vocational nurse (LVN) 3, stated she was unsure when Resident 28 developed current wound under the left eye.<br><br>A review of the facility's policy and procedure titled Skin Tears - Abrasions (scrape) and minor breaks, Care of revised on 9/2013, indicated to notify physician of any abnormalities such as excessive bleeding, localized swelling, redness, drainage or tenderness or skin tears.<br><br>2. A review of Resident 31's Admission Record indicated the facility admitted the resident on 8/27/2021, with diagnoses that included gastro- esophageal reflux disease and intervertebral disc degeneration.<br><br>A review of Resident 31's Minimum Data Set (MDS- A comprehensive assessment and screening tool) Dated 12/1/2024, indicated Resident 31 had severely impaired cognition and required maximal assistance with activities of daily living.<br><br>A review of Resident 31's Care plan for gastroesophageal reflux disease initiated on 8/28/2021, indicated to monitor for poor appetite/ intake, as well as to observe for contributing factors of fluid volume depletion such as vomiting copious (large amount) secretions and notify MD (Medical Doctor) as needed.<br><br>A review of Resident 31's Progress notes dated from 12/23/24 - 1/20/25, indicated no documentation of the root cause of Resident 31's daily regurgitation (vomiting). In addition, there was no documented evidence that the MD was informed or any change of condition (COC).<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 1/21/25 at 11:14AM, observed Resident 31 motioning with hand to her mouth, and large bucket was next to her bed.<br><br>During an interview on 1/21/25 at 11:14 AM, with Marketing Director, Marketing Director stated Resident31 has a bucket next to her bed to be used when throwing up in which he had witnessed Resident 31 vomiting frequently.<br><br>During an interview on 1/21/25 at 11:22 AM, with Licensed Vocational nurse 3 (LVN)3, LVN 3 stated Resident 31 has frequent episodes of vomiting but is unsure if she has lost weight.<br><br>During an interview on 1/23/2025 at 11:26 AM, LVN 3 stated Resident 31 vomits most days she works at facility, but she does not document in the resident ' s progress notes the frequency or duration of Resident 31's vomiting. LVN 3 further stated Resident 31's electrolytes were not being monitored.<br><br>During an interview on 1/23/25 at 1:34PM, with Registered Nurse (RN)1, RN1 stated Nursing staff should be documenting how often and how many times Resident 31 was vomiting or regurgitating her food or liquids. RN 1 stated the MD should be notified if the Resident 31 was vomiting.<br><br>During a concurrent interview and record review on 1/23/25 at 1:34 PM with Registered Nurse 2 (RN2), Resident 31 ' s Progress notes dated from 12/23/24 - 1/20/25 was reviewed and indicated no documentation had been done for Resident 31 ' s daily regurgitation (vomiting). Additionally, RN 2 stated there was no documentation in progress notes regarding daily vomiting or how long the resident had been having episodes of vomiting. RN 2 also stated there was no documented evidence that the primary physician was notified of Resident 31 ' s episodes of vomiting.<br><br>A review of the facility ' s policy and procedure titled Change in a resident ' s condition or Status, Revised on 02/2021, indicated our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident ' s medical/ mental condition and /or status (changes in level of care). |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854<br><br>Based on observation, interview, and record review, the facility failed to ensure the intravenous (IV- a thin, flexible tube that is inserted into a vein) catheter dressing was labeled with the date and time on when the IV dressing was changed, and the name or initial of the staff who changed the dressing.<br><br>This deficient practice placed Resident 39 at risk of complications associated with IV insertion such as infection that can travel to the blood and result in sepsis (a severe life-threatening infection in the blood).<br><br>Findings:<br><br>A review of Resident 39 ' s Admission Record indicated the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included surgical amputation (surgical removal of a body part), diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and osteomyelitis (inflammation of bone or bone marrow, usually due to infection).<br><br>A review of Resident 39 ' s History and Physical (H&P), dated 12/29/2024, indicated the resident has the capacity to understand and make decisions.<br><br>A review of Resident 39 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/2/2025, the resident has intact cognition.<br><br>A review of Resident 39 ' s Order Summary Report, dated 1/24/2025, included an order for the following:<br><br>Meropenem [an antibiotic, a medication that treats infections] Intravenous Solution Reconstituted [medication in powder form mixed with a liquid solution] 1GM [GM, gram, a unit of measuring weight] Use 1 gram intravenously every 12 hours, ordered on 12/28/2024.<br><br>During a concurrent observation and interview on 1/21/2025 at 9:22 AM inside Resident 39 ' s room, Resident 39 was observed lying in bed with an IV catheter (a small plastic tube inserted into the vein) on the right hand that was covered by a white gauze dressing. The dressing did not have any labels that indicated the date and time for when it was applied, nor the name or initial of the nurse that applied the dressing. Resident 39 stated he does not remember when the IV dressing was changed.<br><br>During a concurrent interview and record review on 1/24/2025 at 9:29 AM with RN 1, Resident 39 ' s entire medical records were reviewed. RN 1 stated there was no documented evidence that Resident 39 ' s IV catheter dressing was changed in the past 3 days. RN 1 stated the facility policy was to change the gauze dressings every 48 hours or when it gets soiled.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview on 1/21/2025 at 9:43 AM inside Resident 39 ' s room, RN 1 stated Resident 39 ' s IV catheter dressing did not have any labels that would indicate the date, time, or the person that applied the dressing. RN 1 stated it is the facility ' s policy that IV catheter dressings should be labeled with the date and time for when it was applied, and the initials of the nurse that applied the dressing.<br><br>During an interview and concurrent interview on 1/24/2025 at 9:34 AM with RN 1, the facility ' s policy and procedure (P&P) titled, Peripheral Catheter Dressing Change, dated 3/2023, was reviewed. RN 1 stated the P&P indicated that IV catheter dressing must be labeled with the date, time, and the nurse ' s initials. RN 1 stated not labeling the dressing could put the resident at risk for infections at the site because staff would not know if the dressing needed to be changed.<br><br>During a review of the facility ' s P&P titled, Peripheral Catheter Dressing Change, dated 3/2023, the P&P indicated gauze dressing changes are changed every 48 hours or if the integrity of the dressing is compromised. The P&P also indicated the nurse must label dressing with date, time, and nurse ' s initials. |