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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>555663 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY COMPLETED<br><br>07/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Lindsay Gardens Nursing & Rehabilitation |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1011 W. Tulare Road<br>Lindsay, CA 93247 |  |

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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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37683</b></p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure a Minimum Data Set (MDS) assessment accurately reflected the status of 1 (Resident #57) of 21 sampled residents.</p> <p>Findings included:</p> <p>A facility policy titled, Certifying Accuracy of the Resident Assessment, revised 11/2019, indicated, 2. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. 3. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. Different items on the MDS may have different observation periods. 4. The Resident Assessment Coordinator is responsible for ensuring that an MDS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the Resident Assessment Coordinator, who is a registered nurse.</p> <p>An Admission Record revealed that Resident #57 was admitted to the facility on [DATE]. According to the Admission Record, the resident had a medical history that included dependence on renal dialysis and chronic kidney disease.</p> <p>Resident #57's Order Summary Report, with active orders as of 07/18/2024, indicated the resident had an active order with a start date of 10/18/2023 for hemodialysis at a dialysis center every Monday, Wednesday, and Friday.</p> <p>Resident #57's Care Plan included a focus area, initiated 10/17/2023, that indicated the resident required hemodialysis related to end-stage renal failure. Interventions directed staff to ensure the resident was transported for hemodialysis at a dialysis center.</p> <p>A quarterly MDS, with an Assessment Reference Date (ARD) of 04/30/2024, indicated Resident #57 did not receive dialysis during the assessment period.</p> <p>During an interview on 07/15/2024 at 2:37 PM, the MDS Coordinator stated Resident #57 required dialysis and stated the quarterly MDS assessment was coded incorrectly.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 07/18/2024 at 9:14 AM, the Director of Nursing (DON) stated it was her expectation for residents' MDS assessments to be coded accurately. The DON stated the facility's MDS Coordinator was responsible for ensuring MDS accuracy. The DON stated MDS accuracy was important because the assessment drove everything, including billing. The DON confirmed Resident #57's MDS was inaccurately coded. She stated she assumed Resident #57's MDS regarding dialysis was a mistake because all of the resident's prior assessments were coded accurately.</p> <p>During an interview on 07/18/2024 at 9:38 AM, the Administrator stated it was his expectation for MDS assessments to be accurate and reflect the resident's current status.</p> |   |  |

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| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>28193</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure 1 (Resident #38) of 2 residents reviewed for Preadmission Screening and Resident Review (PASARR or PASRR) was referred for a Level II PASARR assessment when the resident was newly diagnosed with a serious mental illness.</p> <p>Findings included:</p> <p>A facility policy titled, Admission Criteria PASARR, revised 03/2019, revealed, 9.b.(1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD [mental disorder], ID [intellectual disability] or RD [related disorders]. (2) The social worker is responsible for making referrals to the appropriate state-designated authority. c. Upon completion of the Level II evaluation, the State PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.</p> <p>An Admission Record revealed the facility admitted Resident #38 on 12/29/2023. According to the Admission Record, the resident had a medical history that included a primary admission diagnosis of muscle wasting and atrophy.</p> <p>Resident #38's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 12/26/2023, revealed under the Section III - Serious Mental Illness - Definition portion for question 10, Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? the answer was marked No. The Level I screening was Negative, with No Serious Mental Illness, and a Level II screening was Not Required.</p> <p>A Psychologist Consultation/Follow-Up, dated 01/07/2024, for Resident #38 revealed the resident cursed at staff, experienced hallucinations and delusions, and was placed on Seroquel 50 mg (milligrams) three times a day for schizoaffective disorder manifested by combativeness. The consultation/follow-up revealed the psychologist's diagnostic impression was the resident had diagnoses of depressive episode, anxiety disorder, and schizoaffective disorder.</p> <p>Resident #38's Admission Record revealed the resident received a diagnosis of schizophrenia with an onset date of 01/08/2024.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/14/2024, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident had an active diagnosis of schizophrenia.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 07/17/2024 at 2:22 PM, the Director of Nursing (DON) stated she was responsible for PASARRs screenings. The DON stated the facility arranged for a psychiatric consultation after admission to the facility and Resident #38 received a new diagnosis of schizophrenia after the resident was admitted . The DON stated she was responsible for submitting referrals for residents with a newly diagnosed mental illness for PASARR screening; however, she stated she did not make a referral for Resident #38. The DON stated she was not aware of Level II PASARR screenings.</p> <p>During an interview on 07/18/2024 at 9:38 AM, the Administrator stated it was his expectation for PASARR documents to be completed accurately and timely. He also stated that when there was a new diagnosis, the PASARR needed to be resubmitted for review.</p> |   |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37683</p> <p>Based on interview, record review, and facility policy review, the facility failed to follow physician's orders for 2 (Resident #33 and Resident #84) of 5 residents reviewed for unnecessary medications. Specifically, the facility staff failed to administer insulin as ordered by the physician to Resident #33, and the facility failed to administer metoprolol and insulin as ordered by the physician to Resident #84.</p> <p>Findings included:</p> <p>A facility policy titled, Administering Medications, revised 12/2012, specified, 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 5. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns.</p> <p>1. An Admission Record revealed Resident #33 was admitted to the facility on [DATE]. According to the Admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/30/2024, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident had an active diagnosis of diabetes mellitus and had received insulin injections daily during the assessments seven-day lookback period.</p> <p>Resident #33's Care Plan included a focus area, initiated 02/07/2020, that indicated the resident had diabetes mellitus. Interventions directed staff to monitor/document/report to the physician any signs/symptoms of hypoglycemia or hyperglycemia (initiated 02/07/2020).</p> <p>Resident #33's Order Summary Report, with active orders as of 07/17/2024, indicated the resident had an active order with a start date of 07/09/2021 for Lantus SoloStar solution pen-injector 100 unit/milliliter (ml) with instructions to inject 10 units subcutaneously at bedtime for diabetes.</p> <p>Resident #33's Medication Administration Record [MAR], for 05/2024, revealed on 05/17/2024 at 10:00 PM, Licensed Vocational Nurse (LVN) #1 documented the resident's blood glucose was 133 milligrams per deciliter (mg/dL) and a chart code 4 for the resident's Lantus insulin. Per the MAR, the chart code 4 indicated Vital Signs outside of parameter and the medication was not administered.</p> <p>Nursing Progress Notes, dated 05/17/2024 at 9:46 PM, indicated Resident #33's insulin was held because, Vitals below parameters.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a telephone interview on 07/18/2024 at 11:05 AM, LVN #1 stated that if the resident's blood sugar was below 90 mg/dL, she held the resident's nightly insulin, notified the doctor, and document her actions. LVN #1 stated she did not know why she would have held Resident #33's insulin on 05/17/2024 if the resident's blood sugar was 133 mg/dL.</p> <p>Resident #33's MAR for 07/2024, revealed that on 07/01/2024 at 10:00 PM, LVN #2 documented a chart code 5 for the resident's Lantus insulin injection. Per the MAR, the chart code 5 indicated Hold / See Nurse Notes.</p> <p>Nursing Progress Notes, dated 07/01/2024 at 10:31 PM, indicated Resident #33's Lantus insulin was on order.</p> <p>During a telephone interview on 07/17/2024 at 10:14 AM, LVN #2 stated the morning nurse told her that she noticed Resident #33's insulin was missing and placed an order for the medication that morning.</p> <p>2. An Admission Record revealed that Resident #84 was admitted to the facility on [DATE]. According to the Admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus and essential hypertension.</p> <p>A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/23/2024, revealed Resident #84 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had a diagnosis of diabetes mellitus and received insulin injections four days during the assessments seven-day lookback period.</p> <p>Resident #84's Care Plan included a focus area revised on 01/09/2024 that indicated the resident had diabetes mellitus. Interventions directed staff to administer diabetes medication as ordered by the doctor. The Care Plan also included a focus area initiated on 11/02/2023 that indicated Resident #84 had hypertension related to their lifestyle. Interventions directed staff to administer anti-hypertensive medications as ordered (initiated 11/02/2023).</p> <p>Resident #84's Order Summary Report, with active orders as of 07/16/2024, revealed the resident had an order with a start date of 11/23/2023 for insulin glargine subcutaneous solution pen-injector 100 unit/ml with instructions to inject 40 units subcutaneously at bedtime for diabetes mellitus. Further review revealed the glargine order did not indicate the insulin should be held based on blood sugar levels. The Order Summary Report revealed an order with a start date of 02/25/2024 for metoprolol tartrate 25 milligrams (mg) with instructions to give one tablet by mouth one time a day for hypertension. According to the order, staff were to hold the metoprolol if the resident's systolic blood pressure (SBP) was less than 100 millimeters of mercury (mm/Hg), the diastolic blood pressure (DBP) was less than 60 mmHg, or the pulse was less than 60 beats per minute (bpm).</p> <p>Resident #84's Medication Administration Record [MAR], for 05/2024 revealed on 05/09/2024 at 10:00 PM and 05/17/2024 at 10:00 PM, Licensed Vocational Nurse (LVN) #2 documented a chart code 5 for the resident's metoprolol doses, which indicated Hold/See Nurse Notes. According to the MAR, staff documented on 05/09/2024 at 10:00 PM, the resident's blood pressure was 103/67 mm/Hg and pulse was 96 bpm and on 05/17/2024 at 10:00 PM, the resident's blood pressure was 106/63 mm/Hg and pulse was 81 bpm.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Resident #84's Progress Notes, dated 05/09/2024 at 9:35 PM, indicated the metoprolol was held because the resident's blood pressure was lower than parameters.</p> <p>Resident #84's Progress Notes, dated 05/17/2024 at 9:51 PM, indicated the metoprolol was held due to ordered blood pressure and pulse parameters.</p> <p>Resident #84's MAR for 05/2024 indicated that on 05/28/2024 at 10:00 PM, LVN #1 documented a chart code 4 (Vital Signs outside of parameter) and a blood glucose level of 135 milligrams per deciliter (mg/dL) for the resident's glargine insulin.</p> <p>Resident #84's MAR for 06/2024 revealed LVN #2 documented a chart code 5 (Hold/See Nurse Notes) for the resident's metoprolol on 06/16/2024 and 06/28/2024 at 10:00 PM. The MAR revealed on 06/16/2024, staff documented the resident's blood pressure was 103/65 mmHg and pulse was 84 bpm, and on 06/28/2024, staff documented the resident's blood pressure was 114/62 mmHg and pulse was 67 bpm. Further review of the MAR revealed LVN #2 documented a chart code 4 (Vital Signs outside of parameter) 06/29/2024 and 06/30/2024. The MAR revealed staff documented on 06/29/2024 that Resident #84's blood pressure was 101/64 mmHg and pulse was 64 bpm, and on 06/30/2024 when the resident's blood pressure was 111/68 mmHg and pulse was 74 bpm.</p> <p>Resident #84's Progress Notes, dated 06/16/2024 at 9:31 PM; 06/28/2024 at 10:18 PM, 06/29/2024 at 10:08 PM, and 06/30/2024 at 9:11 PM, indicated the metoprolol was held due a SBP less than 100 mm/Hg, a DBP less than 60 mm/Hg, or a pulse less than 60 bpm.</p> <p>Resident #84's MAR for 06/2024 revealed LVN #2 documented a chart code 5 (Hold/See Nurse) for glargine insulin on 06/28/2024 at 10:00 PM, when the resident's blood sugar was 115 mg/dL. On 06/30/2024 at 10:00 PM, LVN #2 documented a chart code 11, which indicated Blood Glucose below parameter for glargine insulin when the resident's blood sugar was 94 mg/dL.</p> <p>Resident #84's MAR for 07/2024 revealed for glargine insulin LVN #2 documented a chart code 5 (Hold/See Nurse Notes) and a blood glucose of 108 mg/dL on 07/08/2024, a blood glucose of 127 mg/dL on 07/13/2024, and a blood glucose of 110 mg/dL on 07/14/2024.</p> <p>During a telephone interview on 07/16/2024 at 1:56 PM, LVN #1 stated she took a resident's blood pressure before administering their blood pressure medications. She stated if the blood pressure was within parameters, she administered the medication as ordered. LVN #1 stated if the blood pressure was outside of the parameters, she held the medication. According to LVN #1, she had also held medications per her nursing judgment if the resident's vital signs were close to being outside the parameters. LVN #1 stated if she held the medication she sent a text message to the doctor and documented the notification in the progress notes. However, according to LVN #1, she could not remember if there were specific progress notes documenting the conversations with the physician for every instance the medication was held.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a telephone interview on 07/16/2024 at 3:27 PM, LVN #2 stated she gave blood pressure medications if the residents' vitals were within physician ordered parameters, and she held the medications if their vital signs were outside of those parameters. LVN #2 stated because Resident #84's blood pressure drops at night, she had made the decision to hold the resident's blood pressure medication if it was close to the threshold. Per LVN #2, she had notified the doctor about the resident's low blood pressure and asked whether he wished to discontinue the medications; however, the physician declined to discontinue the medication but decreased the dosage. LVN #2 stated she could not remember where this conversation was documented.</p> <p>During a follow-up telephone interview on 07/18/2024 at 11:08 AM, LVN #2 stated the only reason she would hold a resident's nighttime insulin was if the resident did not eat, and she did not want the blood sugar to drop further in the night. She stated she usually talked with the physician and documented progress notes; however, she also stated she was not good with documenting those conversations in the progress notes.</p> <p>During an interview on 07/17/2024 at 9:07 AM, the Director of Nursing (DON) stated that blood pressure medications should have been given if they were within parameters of the physician orders for administration. The DON stated if the nursing staff disagreed with the order, they should have contacted the doctor for clarification. The DON stated her concern with holding blood pressure medications was the resident entering a hypertensive stage.</p> <p>During a telephone interview on 07/17/2024 at 9:25 AM, Medical Doctor (MD) #7 stated that his vital sign parameters for Resident #84's metoprolol may have been too conservative. He stated nurses contacted him frequently about whether the medication should be given. However, he stated Resident #84 had hyperthyroidism, which could lead to tachycardia (elevated heart rate) and palpitations, and he wanted metoprolol to be administered because it was important for controlling tachycardia.</p> <p>During a follow-up interview on 07/17/2024 at 10:53 AM, the DON stated staff should follow physician's orders for insulin. The DON stated if there were no physician ordered parameters to hold the insulin, nurses should not hold the medication for any resident, unless the resident refused the medication.</p> <p>During a follow-up telephone interview on 07/17/2024 at 11:17 AM, MD #7 stated that he received many phone calls regarding the administration of glargine insulin to Resident #84 and stated the nurses were subjectively unclear about whether to administer the medication. However, he stated he wanted nursing staff to contact him if they were unsure whether the insulin should be given, because they may have better data regarding what the resident ate. He also stated these conversations between him, and the nursing staff were expected to be documented in the medical record.</p> <p>During an interview on 07/18/2024 at 10:02 AM, the Administrator stated that he expected staff to administer medications as ordered by the physician.</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37683</p> <p>Based on record review, interview, and facility policy review, the facility failed to provide routine pharmaceutical services to ensure medications were available for administration for 1 (Resident #33) of 5 residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>A facility policy titled, Medication Ordering and Receiving from Pharmacy, dated 2015, specified, 2. If not automatically refilled by the pharmacy, repeat medications (refills) are (written on a medication order form/ordered by peeling the top label from the physician order sheet and placing it in the appropriate area on the order form and provided by the pharmacy for that purpose and) ordered as follows: a. Reorder medication (three to four) days in advance of need to assure an adequate supply is on hand. b. The nurse who reorders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling errors. c. The refill order is called in, faxed in, or otherwise transmitted to the pharmacy.</p> <p>An Admission Record revealed Resident #33 was admitted to the facility on [DATE]. According to the Admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/30/2024, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident had an active diagnosis of diabetes and had received insulin injections daily during the assessments seven-day lookback period.</p> <p>Resident #33's Care Plan included a focus area, initiated 02/07/2020, that indicated the resident had diabetes mellitus. Interventions directed staff to monitor/document/report to the physician any signs/symptoms of hypoglycemia or hyperglycemia (initiated 02/07/2020).</p> <p>Resident #33's Order Summary Report, with active orders as of 07/17/2024, indicated the resident had an active order with a start date of 07/09/2021 for Lantus SoloStar solution pen-injector 100 unit/milliliter (ml) with instructions to inject 10 units subcutaneously at bedtime for diabetes.</p> <p>Resident #33's Medication Administration Record [MAR], for 06/2024, indicated that Licensed Vocational Nurse (LVN) #2 documented that the resident's blood sugar was 198 milligrams per deciliter (mg/dL) and Lantus insulin was administered on 06/30/2024 at 10:00 PM.</p> <p>Resident #33's MAR, for 07/2024, revealed LVN #2 documented a chart code 5 for the resident's Lantus insulin injection for 07/01/2024 at 10:00 PM. Per the MAR, the chart code 5 indicated Hold / See Nurse Notes.</p> <p>Nursing Progress Notes, dated 07/01/2024 at 10:31 PM, indicated Resident #33's Lantus insulin was on order.</p> <p>(continued on next page)</p> |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>555663  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY COMPLETED<br><br>07/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Lindsay Gardens Nursing & Rehabilitation   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1011 W. Tulare Road<br>Lindsay, CA 93247 |  |
| 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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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a phone interview on 07/17/2024 at 10:14 AM, LVN #2 stated she did not remember Resident #33 running out of insulin her shift on 06/30/2024, when she administered Lantus to the resident. She stated if the resident was out of the medication or was running low, she would have reordered. Per LVN #2, when she arrived at the facility on 07/01/2024, Resident #33 did not have any insulin. LVN #2 stated the morning nurse noticed it was missing and placed the order for the medication that morning. LVN #2 stated that once medications were ordered it took approximately one day for it to be delivered to the facility. She stated it was the facility expectation to reorder or refill a resident's medication before it ran out. LVN #2 stated if the medication had not already been reordered when the last dose of medication was administered, it should be reordered at that time.</p> <p>During an interview on 07/17/2024 at 10:53 AM, the Director of Nursing (DON) stated that insulin needed to be reordered within two to three days of running out. The DON stated if someone administered the last of the insulin, they should have reordered it, though ideally it would have already been reordered.</p> <p>During an interview on 07/17/2024 at 10:02 AM, the Administrator stated they referred to nursing regarding insulin and refilling medications.</p> |   |  |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28193</p> <p>Based on observation, interview, record review, facility policy review, and review of manufacturer's information, the facility failed to ensure the medication error rate was less than 5 percent (%). Observation of medication administration revealed there were 2 errors out of 35 opportunities, which resulted in a medication error rate of 5.71 %, affecting 2 (Resident #46 and Resident #77) of 5 residents observed during medication administration.</p> <p>Findings included:</p> <p>A facility policy titled, Administering Medications, revised in 12/2012, revealed, Medications shall be administered in a safe and timely manner, and as prescribed.</p> <p>Manufacturer's Instructions for Use Humalog ([NAME]-ma-log) (insulin lispro) injection, for subcutaneous use 3 mL [milliliter] or 10 mL multiple-dose vial (100 units per mL, U [units]-100 revealed, Step 11: Push down on the Plunger to inject your dose. The needle should stay in your skin for at least 5 seconds to make sure you have injected all of your insulin dose.</p> <p>An Admission Record revealed the facility admitted Resident #46 on 05/24/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of type two diabetes mellitus with unspecified complications.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/29/2024, revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment.</p> <p>Resident #46's Order Summary Report, listing active orders as of 07/18/2024, contained an order, started on 09/11/2021, to inject Humalog insulin 100 units per mL per a sliding scale (insulin orders in which the dosage of insulin depends upon the resident's blood glucose reading at the time of administration). According to the order, when the resident's blood glucose was 201-250 milligrams per deciliter (mg/dL), staff were to administer 4 units of Humalog insulin subcutaneously after meals for diabetes.</p> <p>During an observation of medication administration on 07/17/2024 at 11:39 AM, Licensed Vocation Nurse (LVN) #3 obtained Resident #46's blood glucose level, which measured 210 mg/dL and required four units of insulin per the resident's sliding scale insulin order. LVN #3 cleaned a small area on Resident #46's abdomen and administered the insulin without leaving the syringe in place for five seconds after the injection.</p> <p>An Admission Record revealed the facility admitted Resident #77 on 03/25/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of type two diabetes mellitus without complications.</p> <p>A quarterly MDS, with an ARD of 07/02/2024, revealed Resident #77 had a BIMS score of 1, which indicated the resident had severe cognitive impairment.</p> <p>(continued on next page)</p> |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Lindsay Gardens Nursing & Rehabilitation   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1011 W. Tulare Road<br>Lindsay, CA 93247 |  |
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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Resident #77's Order Summary Report, listing active orders as of 07/18/2024, contained an order, started on 07/17/2024, to inject Humalog insulin 100 units per mL per a sliding scale. According to the order, when the resident's blood glucose was 201-250 mg/dL, staff were to administer 4 units of Humalog insulin subcutaneously after meals for diabetes.</p> <p>During an observation of medication pass on 07/17/2024 at 11:52 AM, LVN #3 obtained Resident #77's blood glucose level, which measured 208 mg/dL and required four units of insulin per the resident's sliding scale insulin order. During administration of the four units of insulin, LVN #3 cleaned a small area on Resident #77's abdomen and administered the insulin without leaving the syringe in place for five seconds after the injection.</p> <p>During an interview on 07/17/2024 at 3:15 PM, LVN #3 indicated he was aware he needed to pause after injecting insulin subcutaneously to prevent insulin from leaking out, which could change the number of units of insulin received. He stated he understood it was a medication error and had spoken to the Director of Nursing (DON) about the error.</p> <p>During an interview on 07/18/2024 at 10:07 AM, the DON stated she had spoken to LVN #3 after the medication pass about proper administration of insulin. She stated it was her expectation that medication be given according to the physician's orders, in the right manner.</p> <p>During an interview on 07/18/2024 at 9:43 AM, the Administrator stated it was his expectation that medications be given as ordered by the doctor and given the right way.</p> |   |  |