| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 555805 | A. Building<br>B. Wing | 05/20/2024 |

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| Bel Vista Healthcare Center | 5001 East Anaheim Street<br>East Long Beach, CA 90804 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906<br><br>Based on observation, interview, and record review, the facility failed to assess, care plan, and obtain a physician's order to have the bed against the wall for three of 31 sampled residents (Residents 15, 24 and 28).<br><br>This deficient practice had the potential to result in unnecessary use of a physical restraint (purposely limiting or obstructing freedom of a person's bodily movement).<br><br>Findings:<br><br>a. During a review of Resident 15's Admission Record (Face Sheet), the face sheet indicated Resident 15 was admitted to the facility on [DATE] with diagnosis including cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) and dysphagia (difficulty swallowing).<br><br>During a review of Resident 15's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 4/11/2024, the MDS indicated Resident 15's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 15 had functional limitations in both upper and lower extremities. The MDS indicated Resident 15 was fully dependent on staff for oral hygiene, rolling left to right in bed and for chair/bed-to-chair transfer.<br><br>During an observation on 5/19/2024 at 9:51 a.m., in Resident 15's room, Resident 15's bed was observed with the right side of his bed positioned against the wall. Resident 15's bed was also observed with the left siderail up.<br><br>b. During a review of Resident 24's Face Sheet, Resident 24 was admitted to the facility on [DATE] with diagnosis including left knee osteoarthritis (tissues in the joint [part of the body where two or more bones meet to allow movement] break down over time) and chronic obstructive pulmonary disease ([COPD] a long disease which causes restricted airflow and breathing problems).<br><br>During a review of Resident 24's History and Physical (H&P), dated 7/2/2023, the H&P indicated Resident 24 had fluctuating capacity to understand and make decisions.<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 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 24's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 4/22/2024, the MDS indicated Resident 24's cognition was intact. The MDS indicated Resident 24 had functional limitation on one upper extremity and had functional limitation to both lower extremities. The MDS indicated Resident 24 required partial to moderate assistance from staff for eating and oral hygiene and was fully dependent on staff assistance for rolling left to right in bed.<br><br>During a concurrent observation and interview on 5/19/2024 at 7:54 a.m., with the Licensed Vocational Nurse (LVN) 5, in Resident 24's room, Resident 24's right side of his bed was observed against the wall. Resident 24's bed was also observed with the left siderail up. LVN 5 confirmed Resident 24's right side of the bed was positioned against the wall and the left siderail was up. LVN 5 stated she was not sure why Resident 24's right side of the bed was pushed against the wall. LVN 5 did not adjust Resident 24's bed after she noticed it was positioned against the wall.<br><br>c. During a review of Resident 28's Face Sheet, the face sheet indicated Resident 28 was admitted to the facility on [DATE] with diagnosis including fracture of right tibia (lower leg bone) shaft (shin area), pain, and lack of coordination (not able to move different parts of the body together well).<br><br>During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24's cognition was intact. The MDS indicated Resident 24 had no upper body functional limitations but had a functional limitation of one lower extremity. The MDS indicated Resident 24 required partial/moderate assistance from staff for rolling left to right in bed, sitting to lying in bed, and lying to sitting on the side of the bed. The MDS indicated substantial/maximum assistance from staff for sitting to standing, toilet transfer, and tub/shower transfer. The MDS indicated Resident 24 was continent of bowel and bladder.<br><br>During an observation on 5/18/2024 at 7:36 a.m., in Resident 28's room. Resident 28's bed was observed pushed against the wall.<br><br>During an interview on 5/18/2024 at 5:35 p.m., with Registered Nurse (RN) 1, RN 1 stated Resident's 15, 24 and Resident 28 did not have a physician's order no care plans for having their beds against the wall. RN 1 stated having the bed against the wall could be considered a restraint since it limits the movement of the resident. RN 1 stated having the bed against the wall had a potential to cause the resident to feel trapped due to the restrictions the resident may have by not being able to freely move their body.<br><br>During an interview on 5/19/2024 at 8:38 p.m., with the Director of Nursing (DON), the DON stated I do believe it is important to keep the resident's bed from against the wall but in some of the rooms we have a hard time because the rooms are so small, one of the beds need to be against the wall.<br><br>During an interview on 5/20/2024 at 9:32 a.m., with the DON and Operations Manager (OM) stated Resident's 15, 24 and Resident 28 did not have a bed rail assessment. The DON stated the facility must address the bed against the wall in the resident's comprehensive assessment.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, revised 4/2017, the P&P indicated restraints shall only be used to treat the resident's medical symptom (s) and never for the discipline or staff convenience, or for the prevention of falls. The P&P indicated physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The P&P indicated the definition of restraints is based on the functional status of the resident and not on the device. The P&P indicated if a resident cannot remove a device in the manner in which the staff applied it given that resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint.<br><br>45028 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028<br><br>Based on interview, and record review, the facility failed to report an allegation of staff to resident physical abuse to the California Department of Public Health (CDPH), Local Law Enforcement, and the State Long Term Care Ombudsman ([LTC] public advocate) within the regulated time frame of two hours for one of one sampled resident (Resident 30).<br><br>This deficient practice resulted in CDPH not being aware of the abuse allegation that occurred in 4/2024 until 5/18/2024 and the inability to investigate the allegation on time.<br><br>This deficient practice had the potential for pertinent information to be lost and/or forgotten, more allegations of abuse to go unreported and continued abuse to occur.<br><br>Findings:<br><br>During a review of Resident 30's Admission Record (Face Sheet), the Face Sheet indicated Resident 30 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) and malnutrition (a condition caused by not getting enough calories or the right amount of key nutrients, such as vitamins and minerals, that are needed for health.)<br><br>During a review of Resident 30's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 3/8/2024, the MDS indicated Resident. The MDS indicated Resident 30's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 30 was totally dependent and required two or more staff assistance for oral hygiene, showering, bathing, personal hygiene, and rolling left to right in bed.<br><br>During an interview on 5/18/2024 at 12:40 p.m., with Resident 30's Family Member (FM) 1, FM 1 stated on 4/10/2024, Resident 30 reported to her an allegation that three facility Certified Nurse Assistants were physically aggressive with Resident 30 and dug their fingernails into Resident 30's skin. FM 1 stated she reported the allegations to the Operations Manager (OM).<br><br>During a review of Resident 1's Nurse's Notes and Social Service Notes dated 4/2024, there was no documentation of the allegations.<br><br>During an interview on 5/18/2024 at 2:11 p.m., the Social Services Director (SSD) stated she was not made aware of the allegations. The SSD stated all allegations of abuse should be reported to CDPH, Local Law Enforcement and the Ombudsman within two hours of the allegation.<br><br>During an interview on 5/18//2024 at 6:34 p.m., the OM stated he was made aware of the allegations made by FM 1 but did not consider it abuse since he considered the conversation as informal, and the FM 1 stated the CNAs were aggressive towards Resident 30 and never mentioned physical abuse. The OM stated he did not conduct a thorough investigation of the incident, nor did he report the allegation to the CDPH, Local Law Enforcement or the Ombudsman.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's Policy and Procedure titled, Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating, revised 9/2022, the P&P indicated all reports of resident's abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The P&P indicated if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The P&P indicated immediately is defined as within two hours of an allegation of abuse or result in serious bodily injury. |

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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>45028<br><br>Based on interview, and record review, the facility failed to develop and implement an individualized care plan with measurable objectives, timeframes, and interventions t for two of two sampled residents (Resident 24 and Resident 9) when:<br><br>a. Resident 24's non- compliance on turning and repositioning as part of wound management interventions; and<br><br>b. Resident 9's prescribed anti-anxiety medication (used to treat anxiety [(a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorders) with subsequent monitoring for episodes of anxiety and the response to medications such as side effects and/ or adverse reactions (harmful or unpleasant reaction to medication).<br><br>These deficient practices had the potential to negatively affect the delivery of necessary care and services for Resident 24 and 9).<br><br>Findings:<br><br>a. During a review of Resident 24's Admission Record (Face Sheet), the indicated Resident 24 was admitted at the facility on 2/3/2023 with diagnoses including diabetes mellitus (a condition in which the body fails to metabolize (process) glucose (sugar) correctly ), pressure injury (a breakdown in the skin integrity of a person because of pressure and this usually occurs when a bony part of the body was under persistent contact with an external surface) of the sacral (lower back) area of his body.<br><br>During a review of Resident 24's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 4/22/2024, indicated Resident 24 able to make independent decisions that were reasonable and consistent and was dependent to two or more persons assist to complete his activities of daily living ([ADL] such as dressing, bathing, hygiene, toileting and turning and repositioning in bed).<br><br>During a review of Resident 24's Situation, Background, Assessment and Recommendation (SBAR) Communication Form dated 5/14/2024 timed at 4 p.m., the SBAR indicated Resident 24's Stage 4 (severe tissue damage that occurs when the muscles, tendons and bones are visible at the bottom of the ulcer) pressure injury to the sacral area of his body has increased in size with a measurement of 2 centimeter ([cm] unit of measurement ) by 1.4 cm by 0.2 cm, 90% granulation (the appearance healthy tissue that signifies healing) and 10% slough (dead tissues) peri wound (the area around the wound) area due to non-compliance with turning and repositioning in bed.<br><br>During a review of Resident 24's comprehensive care plan (CP), the CP did not indicate a plan of care was formulated for Resident 24's noncompliance with turning and repositioning in bed.<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 an observation and interview on 5/18/202 at 9:36 a.m., Resident 24 in a supine (lying in bed facing upward) position in a low air loss bed (a special bed designed to prevent skin breakdown) smiled at the surveyor; however, declined to show the dressing and/ or the pressure injury condition on the sacral area of his body.<br><br>During a concurrent interview and record review on 5/19/2024 at 8:12 a.m., with Licensed Vocational Nurse 4 (LVN 4) stated Resident 24's noncompliance to turning and repositioning in bed should have been included in his plan of care so the licensed staff could assess, evaluate, and intervene in accordance with Resident 24's preferences with his care and treatment.<br><br>During an interview on 5/29/2024 at 9:06 a.m., Registered Nurse (RN) 1 stated a plan of care for Resident 24's behavior of non-compliance should have been formulated to be able to identify interventions that will encourage Resident 24 to comply with his care and treatment including an interdisciplinary meeting with Resident 24 and his family.<br><br>During an interview on 5/19/2024 at 2:58 p.m., with the Director of Nursing (DON) stated a plan of care was necessary to provide Resident 24 and his family education on wound care management and prevention of complications.<br><br>b. During a review of Resident 9's Admission Record (Face Sheet), the Face sheet indicated Resident 9 was admitted at the facility on 3/1/2024 with diagnosis of anxiety disorder.<br><br>During a review of Resident 9's Medication Administration Record (MAR) dated 5/2024, the MAR indicated Lorazepam (an anti- anxiety medication) 0.5 milligram (mg-unit of measurement) one tablet every twenty-four hours at night as needed for anxiety as manifested by verbalization of feeling anxious. The MAR did not indicate a behavioral monitoring for verbalization of feeling anxious was completed prior to administration of the anti- anxiety medication to Resident 9.<br><br>During a review of Resident 9's comprehensive care plan, no documentation on plan of care for Resident 9's anti-anxiety medication.<br><br>During a concurrent interview and record review on 5/18/2024 at 4 p.m., RN 1 stated Resident 9 was prescribed an anti-anxiety medication since 3/2024 and the MAR did not indicate Resident 9 was being monitored for behavior of verbalization of feeling anxious prior to administration of the medication and did not indicate Resident 9 was monitored for side effects and adverse effects to the anti- anxiety medication every shift. RN 1 stated there was no plan of care formulated for Resident 9 who was taking an anti- anxiety medication.<br><br>During an interview on 5/19/2024 at 2:58 p.m., DON stated behavior monitoring and identification of the side effects and adverse reactions are necessary to determine if the psychotropic medication (medication for mental illness) was effective or not and if so, a re-evaluation should be done to meet the residents' needs.<br><br>During a review of the facility's Policy and Procedure (P&P) titled Care plans, Comprehensive Person-Centered revised 12/2016, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906<br><br>Based on observation, interview, and record review, the licensed nursing staff failed to follow professional standards of practice for one of one sampled resident (Resident 29) by:<br><br>1. Not flushing (introducing water to the tube) the medication pre and post administration of medication with 30 milliliters ([mL] a unit of measurement) though a gastrostomy ([G-Tube] a surgical opening made into the stomach to provide nutritional support and administer medications to a resident) of water.<br><br>2. Not checking gastric residual (the volume of fluid remaining in the stomach) prior to medication administration.<br><br>3. Not mixing medication with five to 15 mL of water prior to administration per facility's policy and procedure.<br><br>These deficient practices had the potential to cause additional health complications such as dislodgement of the G-Tube, aspiration (food, liquid, or other material enters a person's airway and eventually the lungs), abdominal distention (bloating and swelling in the belly area) and discomfort, gastric reflux (stomach contents move up into esophagus (food pipe lining) or for Resident 29 not receiving all the necessary doses of medication. This deficient practice resulted in Resident 29 receiving 560 mL of fluids during medication administration.<br><br>Findings:<br><br>During a review of Resident 29's Admission Record (Face Sheet), the Face Sheet indicated Resident 29 was admitted to the facility on [DATE] with diagnosis including cerebral infarction ([stroke] damage to tissues of the brain due to a loss of oxygen to the area), left hemiplegia (weakness or paralysis [loss of ability to move] on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body which can affect the arms, legs, and facial muscles), dysphagia (difficulty swallowing), and gastrostomy.<br><br>During a review of Resident 29's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 4/24/2024, the MDS indicated Resident 29's had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 29 had functional limitations in both upper and lower extremities.<br><br>During a review of Resident 29's Physician Order Summary Report indicated on 1/24/2024, to flush Resident 29's G-Tube with 30 cubic centimeters ([cc] a measure of volume) of water before and after each medication administration.<br><br>During a review of Resident 29's untitled Care Plan dated 1/25/2024, the Care Plan indicated Resident 29 required tube feeding related to dysphagia, resisting eating and weight loss. The Care Plan goal indicated Resident 29 will be free of aspiration through a review date of 5/7/2024. The Care Plan interventions indicated for the Licensed Nurses to check the physician's orders for flushing the G-Tube with medication administration.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 5/19/2024 at 8:34 a.m., in Resident 29's room, the Licensed Vocational Nurse (LVN) 5 was observed preparing to administer the following medications:<br><br>1. Amlodipine Besylate (medication used to treat high blood pressure and chest pain) 5 milligrams ([mg] a unit of measurement of mass) twice a day (BID).<br><br>2. Ascorbic Acid ([Vitamin C] vitamin used for growth and repair of tissues [group of cells which perform a specific function] in all parts of the body) 500 mg daily.<br><br>3. Aspirin (medication used to prevent heart attack or stroke) 81 mg daily.<br><br>4. Clopidogrel Bisulfate (a type of blood thinner medication used to prevent stroke, heart attack and other heart problems) 75 mg daily.<br><br>5. Lansoprazole (medication used to reduce stomach acid) 30 mg daily.<br><br>6. Multivitamin-Minerals (vitamin used to treat or prevent vitamin deficiency) 1 tablet daily.<br><br>7. Baclofen (medication used to treat muscle spasms) 5 mg 2 two times a day (BID).<br><br>8. Metoprolol 25 mg (medication used to treat high blood pressure, chest pain and heart failure [a chronic condition in which the heart doesn't pump blood as well as it should]) BID.<br><br>During a continued observation on 5/19/2024 at 8:41 a.m., prior to administering Resident 29's medications, LVN 5 did not check Resident 29's gastric residual prior to administering the first medication. LVN 5 was observed flushing Resident 29's G-Tube with 30 mL with water then LVN 5 was observed withdrawing 60 mL of the first medication dissolved in water with the syringe and push the medication into Resident 29's G-Tube with the plunger. LVN 5 was observed withdrawing 70 mL of the second medication dissolved in water with the syringe and push the medication into Resident 29's G-Tube with the plunger. LVN 5 was observed withdrawing 60 mL of the third, fourth, and fifth medication's dissolved in water (totaling 180 mL) with the syringe and push the medications into Resident 29's G-tube with the plunger. LVN 5 was observed withdrawing 70 mL of the sixth medication dissolved in water with the syringe and push the medication into Resident 29's G-Tube with the plunger. LVN 5 was observed withdrawing 60 mL of the seventh and eighth medication dissolved in water (totaling 120 mL) with the syringe and push the medications into resident 29's G-Tube with the plunger. LVN 5 was observed flushing Resident 29's G-Tube with 30 mL of water after the eight medications to Resident 29. Resident 29 received a total of 560 mL of water during medication administration.<br><br>During an interview on 5/19/2024 at 9:34 a.m., with LVN 5, LVN 5 stated she was told that if she added additional water to the medications, she considered the additional water as the flush and was not required to flush the medication with plain water after the medication was administered. LVN 5 stated she was not aware of the MD order to flush Resident 29's G-Tube with 30 mL after each medication administration, nor was she aware of Resident 29's care plan to check MD orders for flushing Resident 29's G-Tube with medication administration. LVN 5 stated she was not aware of the facility's policy stating when administering medications, medications are crushed and mixed with 5-15 mL of water prior to administration via the G-tube.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/19/2024 at 9:58 a.m., with the Director of Nursing (DON) stated prior to administering medications through the G-tube, it was important for the licensed nurses to check the gastric residual prior to administering the medications so that if the residual was high, the medications may be held, and the need to notify the physician. The DON stated after each medication, the G-Tube was to be flushed with at least 15-30 mL of water between each medication to avoid potential interaction of the medications and to ensure the resident received all their medications. The DON stated, when the medication was overly diluted with water, there was a potential for the resident to get too much water during the medication administration, thus potentially leading to dislodgement of the G-Tube, aspiration from regurgitation of gastric contents into the lungs, abdominal distention, abdominal discomfort, and gastric reflux.<br><br>During a review of the facility's policy and procedure (P&P) titled, General Guidelines for Administering Medication Via Enteral Tube, revised 1/2018, the P&P indicated the facility assures the safe and effective administration of enteral formulas and medications via enteral tubes. The P&P indicated enteral tubes are flushed with 10-15 mL (or prescribed amount) between each medication, and after all medications have been administered with another 15-30 mL of water. The P&P indicated the enteral tubing is flushed with at least 15 mL of water between each medication to avoid physical interaction of the medications. The P&P indicated tablets, powders, and beads from opened capsules are mixed with 5-15 mL of water prior to administration via the tube.<br><br>45028 |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028<br><br>Based on observation, interview, and record review, the facility failed to ensure one of 31 sampled resident's (Resident 30) got out of bed as ordered and was offered to get out of bed when he requested to attend the facility's Cinco De Mayo Festivities.<br><br>This deficient practice resulted in Resident 30's not getting out of bed since his admission to the facility on [DATE], feeling of sadness, and inability to participate in the Cinco de Mayo Festivities.<br><br>Findings:<br><br>During a review of Resident 30's Admission Record (Face Sheet), the Face Sheet indicated Resident 30 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it), abnormalities of gait (manner of walking) and mobility, and lack of coordination.<br><br>During a review of Resident 30's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 3/8/2024 the MDS indicated Resident 30's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 30 was totally dependent and required two or more staff assistance for oral hygiene, showering, bathing, personal hygiene, and rolling left to right in bed.<br><br>During a review of Resident 30's Order Summary Report (physician's orders), dated 2/4/2024, the physician's orders indicated an order was placed for Resident 30 to get out of bed as tolerated and wheelchair mobility.<br><br>During a review of Resident 30's Care Plan titled, Activities of Daily Living ([ADLs] activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating), initiated 3/4/2024, indicated Resident 30 will perform transfers to and from a bed to a chair (wheelchair) with substantial/max assistance from staff. The care plan interventions indicated to guide Resident 30 to and from a bed to a chair (wheelchair) using a device if needed.<br><br>During an interview on 5/18/2024 at 12:40 p.m., with Resident 30's Family Member (FM) 1, FM 1 stated since Resident 30's admission on 3/4/2024, Resident 30 never got out of bed. FM 1 stated when the facility was having Cinco de Mayo festivities, Resident 30 requested to get out of bed to participate, but the staff stated they did not have a way to get Resident 30 out of bed because the room is too small to fit the Hoyer lift ([patient lift] help people who are unable to safely stand or walk move from one place to another) to help Resident 30 transfer out of bed. The FM 1 stated the staff stated they didn't have a Geri chair (useful for those with mobility issues and can also be used for bedridden patients who have difficulty sitting upright in a conventional wheelchair) or wheelchair for the resident to sit in.<br><br>During an observation on 5/18/2024 at 1:30 p.m. in Resident 30's room. There was no wheelchair observed in Resident 30's room.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 30's Clinical Record, dated 3/2024 to 5/2024, there was no documentation by the staff indicating Resident 30 got out of bed.<br><br>During an interview on 5/19/2024 at 9:28 a.m. with Certified Nurse Assistant (CNA) 3, CNA 3 stated that it is difficult to maneuver the Hoyer lift, CNA 3 stated that if there is a resident that needs all the equipment and needs extensive to total assistance with 2 staff it is difficult to provide ADLs.<br><br>During an interview on 5/19/2024 at 12:02 p.m., with the Operations Manager (OM) and Maintenance Supervisor (MS), the MS stated there were no Geri chairs in the facility but did have tilting wheelchairs. The MS stated, a Geri chair seems more comfortable since it is like a bed but with that small room it is hard to put Ger-chair inside.<br><br>During an interview on 5/19/2024 at 5:27 p.m., with the Director of Rehabilitation (DOR) the DOR stated based on Resident 30's assessment, Resident 30 required a Hoyer lift for transfer from the bed to chair. The DOR stated he would recommend a high back wheelchair for Resident 30 but did not see any physical therapy notes or physician's orders for resident to have a high back wheelchair. The DOR stated, there should have been attempts to get Resident 30 out of bed because it is beneficial for the resident to engage in out of room activities and to sustain a better quality of life.<br><br>During continued observations of resident rooms on 5/18/2024, 5/19/2024, and 5/20/2024, there was enough space for the nursing staff to provide care and services for Resident 30.<br><br>During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, revised 3/2018, the P&P indicated residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. The P&P indicated residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene. The P&P indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident in accordance with the plan of care, including appropriate support in assistance with mobility.<br><br>CROSS REFERENCE TO F912 |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906<br><br>45028<br><br>Based on interview and record review, the facility failed to:<br><br>1. Ensure one of one sampled resident (Resident 38) who with diagnosis type 2 diabetes mellitus (abnormal blood sugar) and receiving Sitagliptin phosphate ( medication to lower blood sugar) received a weekly complete blood count ([CBC] a laboratory test which gives information about the production of all blood cells in the body) and comprehensive metabolic panel ([CMP] a group of blood tests which provide information about the body's metabolism [chemical reaction in the body's cells which change food into energy]) per physician order.<br><br>2. Ensure Resident 38's blood sugar was checked when Resident 38 had a change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember), behavioral, or functional status which without immediate intervention, may result in complications or death) of increased confusion on 3/4/2024 , in and out of sleep throughout the night, moaning and calling for his family members on 3/7/2024 and slurred speech (slow speech that can be difficult to understand) on 3/10/2024.<br><br>3. Ensure interventions on Resident 38's care plan titled Diabetes Mellitus dated 1/31/2024, which indicated Licensed Vocational Nurses (LVN) and Registered Nurses (RN) will monitor Resident 38, for signs and symptoms of hyperglycemia (high blood sugar) such as increased thirst, dry skin, stupor (altered level of consciousness) , and coma, (a period of prolonged unconsciousness brought on by illness or injury) the results documented and the physician (medical doctor [MD])notified.<br><br>These failures resulted in Resident 38 receiving a delay in diagnosis, care, and treatment. Resident 38 was transferred to a general acute care hospital (GACH) for evaluation and treatment for a critically high blood sugar of 728 milligrams per deciliter ([mg/dL-unit of measurement] blood sugar reference range was from 70-100 mg/dl), hypernatremia (high sodium [salt] level) and tachypnea (rapid breathing over 20 breaths per minute). On 3/10/2024, Resident 38 was admitted to the GACH's Intensive Care Unit ([ICU] a unit with specialized staff, equipment, and standards to handle severe, potentially life-threatening illnesses).<br><br>Findings:<br><br>A review of Resident 38's Admission Record (Face Sheet), indicated Resident 38 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, cancer of the kidney (abnormal growth of cells in your body tissue), and gastrostomy tube ([GT] soft flexible tube surgically placed into the stomach through the abdominal wall to provide nutrition and/or medication).<br><br>A review of Resident 38's History and Physical (H&P), dated 3/14/2024, indicated Resident 38 did not have the capacity to understand and make decisions.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Resident 38's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 2/3/2024, indicated Resident 38 had moderate impairment in cognitive skills for daily decision-making. The MDS indicated Resident 38 had a diagnosis of diabetes mellitus (DM-abnormal blood sugar).<br><br>A review of Resident 38's Care Plan titled Diabetes Mellitus, dated 1/31/2024, indicated Resident 38 will be free from any signs and symptoms of hyperglycemia (high blood sugar) and will have no complications related to diabetes. The Care Plan interventions indicated staff will monitor and document any signs and symptoms of hyperglycemia such as increased thirst, fatigue, dry skin, abdominal pain, stupor, and coma.<br><br>A review of Resident 38's Physician Order Summary Report dated 1/30/2024, indicated Sitagliptin Phosphate 50 milligrams ([mg] unit of measurement) daily orally for diabetes, CBC, and CMP every Wednesday.<br><br>During a concurrent interview and record review on 5/18/2024 at 2:20 p.m., with Registered Nurse (RN) 1, Resident 38's Situation, Background, Assessment, and Recommendation ([SBAR] a structured communication tool which enhances the communication between members of the healthcare team) dated 3/4/2024, was reviewed. The SBAR indicated Resident 38 had increased confusion on 3/4/2024 (unspecified time). The SBAR indicated Licensed Vocational Nurse (LVN) 2 notified Resident 38's Medical Doctor (MD) 1 on 3/4/2024 at 7:47 a.m. and received orders for CBC and CMP due to Resident 38's change of condition. RN 1 stated labs were not drawn until 3/6/2024, (2 days after the order was received), because it was not entered as a<br><br>stat (immediately) order. RN 1 stated Resident 38's blood sugar level was not checked upon Resident 38's change of condition (increased confusion).<br><br>A review of Resident 38's Nurse's Notes dated 3/4/2024 and timed at 6:10 p.m., indicated Resident 38 was disoriented. Nurse's Notes did not indicate Resident 38's blood sugar was checked, or that MD 1 was notified of Resident 38's status (disorientation).<br><br>During a concurrent interview and record review on 5/18/2024 at 2:35 p.m., with RN 1 Resident 38's Weekly Summary Notes dated 3/5/2024 timed at 12:06 a.m., and 4:09 a.m., were reviewed. The Weekly Summary Notes indicated Resident 38 continued to moan and ask<br><br>for past and present family members throughout the day and night hours. RN 1 stated Resident 38's blood sugar was not checked on 3/5/2024, and MD 1 was not notified of Resident 38's altered mental status.<br><br>A review of Resident 38's Nurse's Notes dated 3/6/2024 timed at 4:40 a.m., indicated Resident 38 was in and out of sleep throughout the night, moaning and calling for his family members. The notes did not indicate Resident 38's blood sugar was checked, or MD 1 notified of Resident 38's status.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 5/18/2024 at 2:42 p.m., with LVN 2, LVN 2 stated when Resident 38 was found with slurred speech on 3/10/2024, he (LVN 2) did not check Resident 38's blood sugar. LVN 2 stated it was possible Resident 2 had hyperglycemia and dehydration because of Resident 38's altered mental status, increased confusion, and dry/cracked lips. LVN 2 stated he contacted the on-call MD 2 by phone on 3/10/2024 at an unknown time, but MD 2 did not respond. LVN 2 stated he should have notified the Director of Nursing (DON) and recommended Resident 38 be transferred to a GACH for further evaluation and treatment.<br><br>During a concurrent interview and record review on 5/18/2024 at 5:35 p.m., with RN 1, Resident 38's SBAR and the Medication Administration Record (MAR) was reviewed. RN 1 stated prior to 3/4/2024, Resident 38 could verbalize his needs and communicate with staff, so the signs and symptom on 3/4/2024 through 3/7/2024 were a significant change in Resident 38's mental status. RN 1 stated prior to 3/4/2024 Resident 38 was able to verbalize if he was in pain to staff. RN 1 stated Resident 38's blood sugar was not checked during the change of condition (COC) on 3/4/2024 through 3/7/2024. RN 1 stated there was no documentation on Resident 38's progress notes or in the MAR to indicate the resident's blood sugar was checked. RN 1 stated license nurses did not check the resident's blood sugar, not even once.<br><br>During a concurrent interview and record review on 5/18/2024 a 6:00 p.m., with RN 1, Resident 38's 72-hour Charting dated 3/6/2024 and timed at 2:47 p.m., was reviewed. The 72-hour Charting indicated Resident 38 was disoriented to situations. RN 1 stated Resident 38's blood sugar was not checked, and MD 1 was not notified of Resident 38's altered mental status.<br><br>A review of Resident 38's Lab Results Report dated 3/6/2024 and reported via telephone to LVN 3 at 9:57 p. m., indicated Resident 38's glucose level was 217 mg/dL, with critical (such a difference from normal, as to be life-threatening unless something is done promptly and for which some corrective action could be taken) laboratory results as follows:<br><br>1. Blood Urea Nitrogen ([BUN] a blood test which measures the amount of urea nitrogen [waste product when the liver breaks down protein] in the blood which if elevated can be indicative of poor kidney function or damage) level of 81 mg/dL. The BUN reference range is between 7-25 milligrams per deciliter (mg/dL-measures fluid volume).<br><br>2. Sodium level to 160 milliequivalents per liter (mEq/L measures fluid volume). The sodium reference range is between 136-145 mEq/L.<br><br>During a concurrent interview and record review on 5/18/2024 at 6:25 p.m., with RN 1 Resident 38's Nurse's Notes dated 3/6/2024 timed at 10:59 p.m., was reviewed. The Nurse's Notes indicated Resident 38 continued to have increased confusion and his lab results were faxed to MD 1 on 3/6/2024 at 10:59 p.m. RN 1 stated there was no documented evidence that MD 1 responded to Resident 38's laboratory results or Licensed Nurses followed up with MD 1 (who was also the Medical Director).<br><br>A review of Resident 38's Nurse's Notes dated 3/7/2024 and timed at 2:55 p.m., indicated Resident 38 continued to have episodes of confusion. The Nurse's Notes did not indicate Resident 38's blood sugar was checked, and that MD 1 was notified of Resident 38's status (change in mental status) or critical lab results from 3/6/2024.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 5/18/2024 at 6:46 p.m., with RN 1 Resident 38's Nurse's Notes dated 3/9/2024 timed at 3:55 p.m., was reviewed. The Nurse's Progress Notes indicated RN 1 notified MD 2 of Resident 38's BMP results. RN 1 stated that she did not inform MD 2 about Resident 38's diagnosis of diabetes. RN 1 stated she informed MD 2 only of the BUN results because RN 1 was concerned about signs and symptoms of dehydration for Resident 38. RN 1 stated other critical laboratory result (Sodium 161 mEq/L) was not relayed to MD 2 and clinical symptoms including increased confusion on 3/4/2024, in and out of sleep throughout the night moaning and calling for his family members on 3/7/2024.<br><br>A review of Resident 38's COC dated 3/10/2024, timed at 11:56 a.m., indicated Resident 38's Family Member (FM) 1 informed LVN 4 that Resident 38 was not responsive as usual.<br><br>A review of Resident 38's SBAR Communication Form dated 3/10/2024, indicated LVN 4 paged MD 2 at 12 p.m., to notify the MD of Resident 38's chapped lips, tear to his upper left lip, and decreased communication (not responding). There was no documentation to indicate Resident 38's blood sugar level was checked, and if MD 2 responded to the page.<br><br>A review of Resident 38's Nurse's Notes dated 3/10/2024 timed at 3:11 p.m., indicated Resident 38 was noted with a slurred speech. The Nurse's Notes indicated MD 2 was called (time not indicated) and awaiting his response. There was no documentation to indicate Resident 38's blood sugar level was checked.<br><br>A review of Resident 38's COC dated 3/10/2024 timed at 6:43 p.m., indicated Resident 38 was still noted with increased weakness and was less verbal. The COC indicated Resident 38's Family Member (FM) 1 requested Resident 38 to be transferred to a GACH for evaluation and treatment. The COC also indicated Resident 38 would be transferred to the GACH via a regular ambulance transport.<br><br>A review of Resident 38's GACH H&P dated 3/10/2024 timed at 7:43 p.m., indicated Resident 38 presented to the Emergency Department (ED) with a respiratory rate ranging between 25 and 37 breaths per minute and increased confusion. The H&P indicated FM 1 stated Resident 38's altered mental status continued to worsen and the resident had labored breathing. The H&P indicated the following laboratory results:<br><br>1. Glucose level of 728 mg/dL. A normal blood glucose level is less than 149 mg/dL.<br><br>2. Sodium level of 146 millimoles per liter ([mmol/L] measures fluid volume. The normal range for blood sodium levels is between 134-145 mmol/L.<br><br>3. Potassium (type of electrolyte [regulate nerve and muscle function]) level of 6.4 mmol/L. The normal range for blood potassium levels is between 3.5-5.2 mmol/L. High levels can cause irregular heartbeat.<br><br>4. Chloride (type of electrolyte) level of 119 mmol/L. The normal range for blood chloride levels is between 101-111 mmol/L. High levels maybe a sign of dehydration.<br><br>5. Blood Urea Nitrogen level of 132 mg/dL. The normal range for BUN levels is between 8-20 mg/dL.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 6. Creatinine (a blood test used to check how well the kidneys are) level of 3.39 mg/dL. The normal range for blood creatinine levels is between 0.44-1.03 mg/dL.) If elevated can be indicative of dehydration, kidney damage or kidney failure)<br><br>The H&P dated 3/10/2024 indicated Resident 38 presented to the ED with high serum osmolality (less water in the blood), a blood pH (a measure of how acidic or basic a substance or solution is) of greater than 7.3. The GACH H&P indicated Resident 38 required subcutaneous (under the skin) insulin (medication to lower blood sugar) administration and calcium gluconate (medication used to lower the level of potassium in the blood) in the ED. The H&P indicated Resident 38 was later admitted to the ICU on 3/10/2024.<br><br>During an interview on 5/18/2024 at 12:42 p.m., with LVN 2, LVN 2 stated on 3/10/2024, when Resident 38 was observed to have a slurred speech, altered mental status, increased confusion, and dry/cracked lips, he (LVN 2) did not check the resident's blood sugar. LVN 2 stated Resident 2 might have had hyperglycemia and dehydration. LVN 2 stated he paged MD 2, but he did not get a response. LVN 2 stated he notified the DON on 3/10/2024 but the DON did not give any recommendation for Resident 38 to be transferred to the GACH.<br><br>During an interview on 5/19/2024 at 12:21 p.m., with LVN 4, LVN 4 stated if a resident had or continued to have an altered level of consciousness, a COC had to be completed to include a blood sugar check, especially if the resident was diagnosed with diabetes. LVN 4 stated when Resident 38 continued to have an altered mental status, she should have been transferred to the GACH immediately. LVN 4 stated she forgot to check Resident 38's blood sugar when Resident 38 had a COC on 3/10/2024. LVN 4 stated she did not notify MD 2, who was the on-call MD that weekend. LVN 4 stated on 3/10/2024 she (LVN 4) paged MD 2 but did not respond. LVN 4 stated she should have notified the DON when she did not get a response from MD 2.<br><br>During an interview on 5/19/2024 at 1:30 p.m., with the DON, the DON stated upon admission of residents in the facility she thoroughly checked the admission orders and clarified medications that required monitoring with the MD the day after admission. The DON stated she continued to monitor new residents until a care planning and Interdisciplinary Team (IDT- different health care disciplines to help receive the care they need) met to make sure nothing was missed with the plan of care. The DON stated it was the responsibility of all licensed nurses to ensure laboratory tests (labs) ordered by the physician were carried out in a timely manner. The DON stated she was responsible to ensure ordered labs (CBC and CMP) were done weekly but she forgot to ensure Resident 38's labs were done, and the MD notified of the resident's four missed CBC and CMP tests in the month of February 2024. The DON stated it was the standard of practice (the usual thing done in a particular situation) to monitor (check blood sugar) a resident's blood glucose levels if the resident was a diabetic and had a COC of altered mental status. The DON stated Resident 38's hospitalization could have been prevented if the resident's weekly CBC and CMP was performed as ordered on 1/31/2024 and Resident 38's MDs notified of any abnormal results. The DON stated unknown and uncontrolled blood sugar levels placed Resident 38 at risk for kidney failure, comatose (a period of prolonged unconsciousness brought on by illness or injury), impaired cognition, and death.<br><br>During a concurrent interview and record review on 5/19/2024 at 1:30 p.m., with the DON, Resident 38's Clinical Record was reviewed. The DON stated there were no CBC and CMP results for the month of February 2024.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Resident 38's Nutritional Narrative Note dated 3/7/2024 and timed at 1:02 p.m., indicated MD 1 had not placed an order for Resident 38's critical labs dated 3/6/2024. The note did not indicate if the Registered Dietician (RD) notified MD 1 of the critical labs.<br><br>During a concurrent interview and record review on 5/20/2024 at 8:28 a.m., with the RD, Resident 38's Admission Nutritional Risk assessment dated [DATE], was reviewed. The RD stated she identified Resident 38 was receiving Sitagliptin but did not check if the licensed staff were monitoring Resident 38's blood sugar. The RD stated Resident 38's blood sugar should have been checked at least daily to monitor if it was stable or not. The RD stated she did not recommend checking Resident 38's blood sugar since his admission on 1/30/2024.<br><br>During a concurrent interview and record review on 5/20/2024 at 11:17 a.m., with MD 1 Resident 38's Lab Results Report dated 3/6/2024, and 3/9/2024, and of Resident 38's Clinical Chart were reviewed. MD 1 stated he ordered weekly CBC and CMP for Resident 38 on 1/30/2024 to help determine Resident 38's fluctuating labs and to monitor the resident's blood glucose levels. MD 1 stated if there was an increase in the blood glucose levels results on the weekly labs, MD 1 could have determined how often Resident 38's blood sugar should have been monitored, whether on a daily, twice daily, or weekly basis. MD 1 stated he was not aware weekly CBC and CMP was not done for Resident 38 as ordered on 1/30/2024. MD 1 stated had the weekly labs been done as ordered, he could have detected a change or abnormal lab results which would correlate with Resident 38's change of condition on 3/4/2024-3/10/2024. MD 1 stated on 3/9/2024, Resident 38 should have been transferred to the GACH for further evaluation immediately after the resident continued to have confusion, altered level of consciousness and critical high lab values that were not improving after intravenous (IV-through the vein) hydration on 3/6/2024.<br><br>A review of the facility's policies and procedures (P&P) titled, Lab and Diagnostic Test Results - Clinical Protocol, revised 11/2018, The staff will process test requisitions and arrange for tests. The P&P indicated Direct a voice communication with the physician was the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status was unstable. The P&P indicated a physician should respond within one hour regarding a lab test result requiring immediate notification. The P&P indicated if the attending or covering physician did not respond to immediate notification within an hour, the nursing staff should contact the Medical Director for assistance.<br><br>A review of the facility's P&P titled, Nursing Care of the Older Adult with Diabetes Mellitus, revised 11/2020, indicated symptoms associated with diabetes included hyperglycemia. The P&P indicated older adults with diabetes were at higher risk for functional impairment, cognitive decline, muscle loss than other older adults. The P&P indicated for a resident on an oral medication (s) who was well controlled, his/her blood glucose levels should be monitored at least twice weekly (or more frequently if there was a change in drugs or drug dosages). The P&P indicated for the resident receiving oral medication(s) who was poorly controlled, blood glucose levels should be monitored two to four times daily, as needed.<br><br>A review of the facility's P&P titled Change in a Resident's Condition or Status, revised 2/2021, indicated prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the SBAR Communication Form. |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537<br><br>Based on observation, interview and record review, the facility failed to ensure two of two sampled residents (Resident 9 and Resident 18) were:<br><br>a. provided assistance in recharging Resident 9's hearing aid; and<br><br>b. provided assistance for Resident 18 to be scheduled for ancillary services such as Eyes, Ears, Nose and Throat consultation and assessed/ determined for a hearing aid.<br><br>These failures has caused Resident 9 and Resident 18 to feel frustrated during their care and treatment which could potentially delay the delivery of their care and services that can inadvertently affect their quality of life.<br><br>Findings:<br><br>A. During a review of Resident 9's Admission Record (face sheet), the Face sheet indicated Resident 9 was admitted at the facility on 3/1/2024 with diagnosis including anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) and repeated falls.<br><br>During a review of Resident 9's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 3/5/2024, the MDS indicated Resident 9 was not identified to have a hearing inadequacy, was able to make independent decisions that were reasonable and consistent, required one-person partial and/or moderate assistance (the helper lifts, holds and/or support the [NAME] or limbs, but provides less than half the effort) to get out of bed.<br><br>During an observation and interview on 5/18/2024 at 9:41 a.m., Resident 9 had a frustrated expression and stated in exasperation that she cannot hear. Resident 9 pointed to her hearing aid on top of her drawer and stated the hearing aid were not recharged so she couldn't use it and she needed the nurse to help her get out of the bed because her family was coming to visit.<br><br>During an observation on 5/18/2024 at 10 a.m., Activity Assistant 1 (AA1) answered the call light of Resident 9 and AA1 told Resident 9 she will inform the nurse so she can be helped. Resident 9 was heard repeatedly asking AA1 what she was telling her.<br><br>B. During a review of Resident 18's Admission Record (face sheet), the Face sheet indicated Resident 18 was admitted at the facility on 3/23/2024 with a diagnosis including chronic respiratory failure (a disorder that happens when the airways that carry air into the lungs become narrow and damaged).<br><br>During a review Resident 18's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 3/2/2024, the MDS indicated Resident 18 was not identified to have a hearing inadequacy, was able to make independent decisions that were reasonable and consistent and required two or more helpers to complete her activities of daily living ({ADL}) task such as bathing, dressing, grooming and toileting).<br><br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview on 5/18/2024 at 10:12 a.m., Resident 18 had a frustrated expression and stated it was frustrating not to be able to hear the staff and the staff knew about it. Resident 18 stated she have a pair of hearing aid at home and if she can't have them at the facility, she needed to be checked because she cannot hear very well.<br><br>During an interview on 5/18/2024 at 10:10 a.m., AA1 stated Resident 9 had difficulty hearing and should be using her hearing aid so she can understand the staff and be able to express herself well.<br><br>During an interview on 5/18/2024 at 10:12 a.m., Certified Nursing Assistant (CNA) 1 stated Resident 9 was hard of hearing and can get uncomfortable if unable to use her hearing aid. CNA 1 stated Resident 1 needed to have a hearing aid because she gets frustrated if she could not understand her care.<br><br>During an interview on 5/18/2024 at 10:15 a.m., Licensed Vocational Nurse (LVN) 1 stated the licensed nurses oversee recharging Resident 9's hearing aid and stated Resident 18 was hard of hearing and did not have and/or was not using a hearing aid. LVN 1 stated if the residents are not able to hear adequately, it could affect their care.<br><br>During a concurrent interview and record review on 5/18/2024 at 1:19 p.m., Registered Nurse Supervisor 1 (RNS 1) stated Resident 9 and Resident 18 despite observed to have difficulty of hearing, were not identified to have such difficulties and there was no care plan formulated to address the concern. RNS 1 stated there will be a delay in the provision of Resident 9 and Resident 18's care and treatment and their quality life will be affected.<br><br>During an interview on 5/19/2024 at 2:44 p.m., the Social Service Director (SSD) stated Resident 9 was seen by the Eyes, Ears, Nose and Throat Doctor and there was no other recommendation but for Resident 9 to use her current hearing aid. SSD stated she was not able to identify Resident 18 to have a hearing impairment on her assessment; however, the nursing staff and her must collaborate in identifying any sensory difficulties that Resident 18 may have to include Resident 18 in the list to be evaluated by the Eyes, Ears, Nose and Throat Doctor.<br><br>During an interview on 5/19/2024 at 2:58 p.m., the Director of nursing Services (DON) stated residents who have a hearing impairment have the potential to feel frustrated that could delay the delivery of their care and treatment and negatively affect their quality of life.<br><br>During a review of the facility's Policy and Procedure (P/P) on Hearing Impaired Resident, Care Of revised 2/2018, the P/P indicated the facility staff must assist the hearing-impaired residents to maintain effective communication with the clinicians, caregivers, other residents, and visitors by:<br><br>1. assisting the resident and their representatives to schedule appointment and transportation to obtain needed services, and<br><br>2. assisting the resident with care and maintenance of their hearing devices. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>45537<br><br>Based on observation, interview, and record review the facility failed to ensure one of one sampled resident (Resident 11) was provided floor mats to both side of her bed, who have a history of falling.<br><br>This failure has the potential for Resident 11 to incur injury and suffer complications associated with a fall.<br><br>Findings:<br><br>During a review of Resident 11's Admission Record (face sheet), the face indicated Resident 11 was admitted at the facility on 9/12/2023 with diagnosis including atrial fibrillation (a condition of irregular heartbeat that occurs when the electrical signals in the chambers of the heart fire rapidly at the same time causing the heart to beat faster than normal) with long term use of anticoagulant (also called a blood thinner; a substance that is used to prevent and treat blood clots in the blood vessels and the hearts) medication, dementia (a condition of loss of brain function that affects one or more brain function such as memory, thinking, language, judgment or behavior), and gait (the way a person walks or run) and mobility (ability to move freely) abnormalities.<br><br>During a review of Resident 11's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 3/11/2024, the MDS indicated Resident 11 had moderate disorientation and was unable to make independent decisions and required substantial maximal assist (helper lifts or hold the trunk or limbs and provides more than half the effort) with one- person assist to complete her activities of daily living ({ADL}) such as dressing, bathing, hygiene, toileting, bed mobility (turning and repositioning) and transferring from chair/bed to chair.<br><br>During a review of Resident 11's Order Summary Report (OSR), the Order Summary Report indicated Resident 11 had a doctor's order dated 4/20/2024 to take Apixaban (an anticoagulant medication; also knows as a blood thinner) 5 (five) mg (a measure of weight equal to one thousandth of a gram) 1 (one) tablet by mouth twice (two times) a day for Atrial Fibrillation.<br><br>During a review of Resident 11's care plan (CP) on Impaired self-care and functional mobility dated 4/26/2024, the CP had a goal for Resident 11 to be able to perform her activities of daily living from substantial maximum assist to supervision with interventions including assessing the safety of the environment.<br><br>During a review of Resident 11's care plan (CP) on 'Falls: Resident had an unwitnessed fall and is at risk for recurring falls, dated 5/4/2024, the CP had a goal for Resident 11 to not have any major injuries related to the occurrence of a fall and minimize complications related to the actual fall to the extent possible with interventions including anticipation and meeting Resident 11's needs, keeping the bed in low position with brakes locked and to provide safety devices such as a fall mat and other non-slip pads.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 5/18/2024 at 5:31 p.m., Resident 11 was in bed taking a nap and there were no fall mats to either side of her bed.<br><br>During an interview and record review on 5/18/2024 at 5:34 p.m., Licensed Vocational Nurse 10 stated Resident 11 had a history of falls in the past and had a recent unwitnessed fall (sitting on the floor beside her wheelchair) and confirmed that one of the interventions in her care plan is to provide safety devices such as fall mats to both side of her bed. LVN 10 stated Resident 11 is currently on an anticoagulant medication with bleeding as one of the side effects.<br><br>During an interview on 5/18/2024 at 5:45 p.m., Registered Nurse 1 (RNS 1) stated the staff must ensure the fall precautions are provided for Resident 11, who was taking an anticoagulant medication, to manage and/or prevent complications of a fall, which could be detrimental to her health.<br><br>During an interview on 5/19/2024 at 2:58 p.m., the Director of Nursing Services (DON) stated she believe following the interventions in the plan of care is necessary to prevent further episodes of fall and prevent potential injuries and complications.<br><br>During a review of the facility's Policy and Procedure (P/P) on Falls and Fall Risk, Managing revised 3/2018, the P/P indicated the facility must identify interventions related to the residents' specific risks and causes to try to prevent residents from falling and to try to minimize complications from falling.<br><br>During a review of the facility's Policy and Procedure (P/P) on Safety and Supervision of Residents revised 7/2017, the P/P indicated the facility must strive to provide supervision and assistance to the residents to prevent accidents and promote safety and should ensure interventions specific in a resident individualized |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028<br><br>Based on interview, and record review, the facility failed to ensure a resident (Resident 140), who received hemodialysis (process of purifying the blood of a person whose kidneys [one of a pair of organs in the abdomen which remove waste and extra water (as urine) and help keep chemicals balanced in the body] are not working normally) intake and output status was monitored per the physician's orders for one of one sampled resident.<br><br>This deficient practice had the potential to over and/or underload Resident 140 with fluid.<br><br>Findings:<br><br>During a review of Resident 140's Admission Record (Face Sheet), the Face Sheet indicated Resident 140 was admitted to the facility on [DATE] with diagnosis including diabetes mellitus (DM) type 2 [a chronic disease characterized by elevated levels of blood glucose (or blood sugar) in a bloodstream] and end stage kidney disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), dependence on renal (kidney) dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), and pleural effusion (the buildup of excess fluid between the tissues which line the lungs [a pair of spongy organs located withing the chest cavity close to the heart] and chest).<br><br>During a review of Resident 140's Nursing Admission assessment dated [DATE], the Nursing Admission Assessment indicated Resident 140's cognition was intact and oriented to person with periods of confusion. The Nursing Admission Assessment indicated Resident 140 required assistance with activities of daily living ([ADLs] activities related to personal care) from staff which included eating, bathing, dressing, grooming/hygiene, toileting, and bed mobility.<br><br>During a review of Resident 140's Order Summary Report ([OSR] physician's orders), the OSR dated 5/16/2024 indicated a physician's order was received for Resident 140 to be on a 1000 milliliter ([mL] a unit of capacity equal to one thousandth of a liter) fluid restriction: 720 mL from dietary and 280 mL from nursing (80 mL from 11 p.m. to 7 a.m., 100 mL from 7 a.m. to 3 p.m., and 100 mL from 3 p.m. to 11 p.m. There were no orders indicating to monitor Resident 140's output.<br><br>During a review of Resident 140's Documentation Survey Report dated 5/2024, there was no documentation indicating the Certified Nurse Assistants (CNAs) monitored Resident 140's intake and output.<br><br>During a review of Resident 140's Nurse's Notes, dated 5/2024, there was no documentation indicating the LNs monitored Resident 140's intake and output.<br><br>(continued on next page) |

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| F 0698<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 5/19/2024 at 1:15 p.m., with Licensed Vocational Nurse (LVN) 2 of Resident 140's Medication Administration Record (MAR), dated 5/2024 was reviewed. The MAR indicated, from 5/16/2024 to 5/19/2024, there were no licensed staff initials in the box for Resident 140's fluid restriction, to demonstrate the fluid restriction was done. LVN 2 stated there was no documentation on the MAR dated 5/16/2024 to 5/19/2024 that indicated Resident 140's fluid restriction was done nor that Resident 140's output was monitored. LVN stated if the LNs don't monitor a dialysis resident's intake, there is a potential for the resident to have fluid overload (having too much water in the body which can lead to heart issues, shortness of breath, and unnecessary hospitalization .<br><br>During an interview on 5/19/2024 at 6:01 p.m., with the Director of Nursing (DON), the DON stated all License Nurses(LN) are responsible for following the physician's orders for fluid restriction and it is important for all LNs to ensure residents who are on dialysis intake and output is monitored to prevent complications relating to fluid overload which may include shortness of breath, congestive heart failure (a chronic [long term] condition in which the heart doesn't pump blood as well as it should), unnecessary swelling, and elevated blood pressure.<br><br>During a review of the facility's undated policy and procedure (P&P) titled, Dialysis, Coordination of care and Assessment of Resident, the P&P indicated the facility will monitor fluid balance through recording and assessment of intake and output. The P&P indicated the facility will notify the dialysis center physician of resident noncompliance of diet/fluid restrictions as indicated. |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906<br><br>Based on observation, interview, and record review the facility failed to ensure resident who has a history of Post traumatic stress disorder (PTSD- a mental health condition that's triggered by a terrifying event either experiencing it or witnessing it) was screen and was assessed for re-traumatization of traumatic experience for one of one sampled resident (Resident 23).<br><br>This deficient practice has the potential for staff unable to identify fears that can bring back trauma.<br><br>Findings:<br><br>During a review of Resident 23's Admission Record (Face Sheet), the face sheet indicated Resident 23 was admitted to the facility on [DATE] with diagnosis including Post traumatic stress disorder (PTSD- a mental health condition that's triggered by a terrifying event either experiencing it or witnessing it), depression (a depressed mood or loss of pleasure or interest in activities for long periods of time),unspecified atrial fibrillation (an irregular and often very rapid heart rhythm).<br><br>During a review of Resident 23's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 4/11/2024, indicated Resident 23's no speech and cognitive skills for daily decision-making were modified independence some difficulty in new situations only.<br><br>During an initial tour to the facility on [DATE] at 8:20 a.m. observed Resident 23 in bed, non-verbal.<br><br>During a record review of the social service note (SSN) dated 4/9/2024, the SSN indicated Social Service Designee (SSD) had IDT with Resident 23's wife and stated that he is nonverbal and does not show any symptoms of PTSD.<br><br>During an interview on 5/18/2024 at 4:46 p.m. with the SSD and record review of the SSN, SSD stated that she referred Resident 23 to psychiatrist at the same day they had an IDT with Resident 23's wife. SSD stated that she does not know if there is an assessment and SSD stated that she does not know what the trauma assessment is. SSD further added that she does not know what could re-traumatize Resident 23.<br><br>During a concurrent interview on 5/19/2024 at 9:58 a.m. with the Director of Nursing (DON) and record review of Resident 23 care plan titled Trauma-informed care dated 4/10/2024, the DON stated the care plan doesn't indicate Resident 23 was assessed with regards to trauma and DON further added facility does not know what the triggers or history are. DON said it could have been better if all facility staff aware and be able to recognize Resident 23's traumatic experiences to avoid re-traumatization.<br><br>During an interview on 5/19/2024 at 1:30 p.m. with Licensed Vocational Nurse (LVN 6), LVN 6 said she is the nurse in charge of Resident 23, but she is not aware what are the triggers that can possibly re-traumatized or can have a flash back of the trauma. LVN 6 stated she could provide specific care if she is aware of the trauma event that Resident 23 has encountered previously.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a record review of the facility's policy and procedure (P &P) titled Trauma Informed Care and Culturally Competent Care dated 08/2022, the P & P indicated develop individualized care plans that address past trauma in collaboration with the resident and family as appropriate. Identify and decrease exposure to triggers that may re-traumatize the resident. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028<br><br>Based on observation, interview, and record review, the facility failed to ensure proper use of bed rails (are adjustable metal or rigid plastic bars that attach to the bed) for two of three sampled residents (Resident 15, 24, and 28), as indicated in the facility's policy and procedure by failing to: assess, monitor, evaluate, and provide care plan for residents with side rails.<br><br>These deficient practices had the potential to result in inappropriate use of bed rails for (Resident 15,24 and 28) that can lead to entrapment and/or injuries.<br><br>Findings:<br><br>a. During a review of Resident 15's Admission Record (Face Sheet), the face sheet indicated Resident 15 was admitted to the facility on [DATE] with diagnosis including cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) and dysphagia (difficulty swallowing).<br><br>During a review of Resident 15's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 4/11/2024, the MDS indicated Resident 15's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 15 had functional limitations in both upper and lower extremities. The MDS indicated Resident 15 was fully dependent on staff for oral hygiene, rolling left to right in bed and for chair/bed-to-chair transfer.<br><br>During an observation on 5/19/2024 at 9:51 a.m., in Resident 15's room, Resident 15's bed was observed with the right side of his bed positioned against the wall. Resident 15's bed was also observed with the left siderail up.<br><br>b. During a review of Resident 24's Face Sheet, Resident 24 was admitted to the facility on [DATE] with diagnosis including left knee osteoarthritis (tissues in the joint [part of the body where two or more bones meet to allow movement] break down over time) and chronic obstructive pulmonary disease ([COPD] a long disease which causes restricted airflow and breathing problems).<br><br>During a review of Resident 24's History and Physical (H&P), dated 7/2/2023, the H&P indicated Resident 24 had fluctuating capacity to understand and make decisions.<br><br>During a review of Resident 24's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 4/22/2024, the MDS indicated Resident 24's cognition was intact. The MDS indicated Resident 24 had functional limitation on one upper extremity and had functional limitation to both lower extremities. The MDS indicated Resident 24 required partial to moderate assistance from staff for eating and oral hygiene and was fully dependent on staff assistance for rolling left to right in bed.<br><br>(continued on next page) |

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| Bel Vista Healthcare Center | 5001 East Anaheim Street<br>East Long Beach, CA 90804 |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | c. During a review of Resident 28's Admission Record (Face Sheet), the face sheet indicated Resident 28 was admitted to the facility on [DATE] with diagnosis including unspecified abnormalities of gait and mobility (pattern that you walk), unspecified fracture of shaft of right fibula (a break to your fibula caused by a forceful impact that results in injury), presence of left artificial hip joint (surgical procedure in which the hip joint is replaced by a prosthetic implant).<br><br>During a review of Resident 28's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/8/2024, indicated Resident 28's has clear speech and can usually be understood by others and has the ability to be understand by others. Resident 28 has impairment on lower extremity but can be set up on eating, oral hygiene and personal hygiene, partial moderate assistance with toileting, shower/bathe self, lower body dressing and putting on/taking off footwear. Resident 28 is not on restraint.<br><br>During an initial round on 5/18/2024 at 7:10 a.m., Resident 28 sleeping in bed two siderails up and bed is against the wall.<br><br>During an interview on 5/18/2024 at 7:21 a.m. with Resident 28, she stated that her bed set up is always like that.<br><br>During an interview on 5/18/2024 at 2:36 p.m. with Certified Nurse Assistant (CNA 3), CNA stated that she is not aware if there is an order, but she always has this set- up with regard to Resident 28's bed.<br><br>During a concurrent interview on 5/19/2024 at 5:34 p.m. with the Director of Nursing (DON) and record review of the Resident 28's physician's order, plan of care and assessment. DON stated she could not find any assessment for the side rails or plan of care. DON stated that it should have a physician order as well as consent for siderails, DON further added the order indicated Resident 28 has a 1/4 side rail to right side of the bed for bed mobility and transfer ability. DON continued reviewing two more residents (Resident 24 and 15) consent, assessment, and care plan. The DON stated that there is nothing for the siderails in two other residents that are being reviewed. DON stated that assessment is important to make sure that it is not restraint and was able to establish that staff are not using it for convenience nor restraining residents to get out of bed.<br><br>During a concurrent interview on 5/20/2024 at 10:45 a.m. with the DON and Administrator, Admin stated that they have the tool to check siderails measurement. The DON stated that it is important to measure the appropriate bed system because of the risk of entrapment especially for Residents that are unable to verbalize. Admin stated that it is the responsibility of the maintenance supervisor (MS) to make sure that it would be measure appropriate prior to installation.<br><br>During a concurrent interview on 5/20/2024 at 10:56 a.m. with the MS and presence of DON and Admin, MS stated that he has the tool, but he has not done it yet, since he is waiting for the person to help him use the tool.MS stated that no side rails or enabler in the bed was measured.<br><br>During a record review of the facility's policy and procedure (P&P) titled Use of Restraints revised 04/2017, It indicated practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted including using bedrails to keep resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a record review of the P &P titled Bed Safety and Bed Rails revised 08/2022, the P&P indicated Residents beds meet the safety specifications established by the Hospital Bed Safety Workgroup. Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. Maintenance staff routinely inspects all beds and related equipment to identify risk and problems including potential entrapment risks. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906<br><br>Based on observation, interview and record review, the facility failed to ensure resident who has a history of Post traumatic stress disorder (PTSD- a mental health condition that's triggered by a terrifying event either experiencing it or witnessing it), and depression (a depressed mood or loss of pleasure or interest in activities for long periods of time) was provided with individualized approach to care and understand resident's distress for one of one sampled resident(Resident 23).<br><br>This deficient practice has the potential not to provide behavioral health care services needed for Resident 23.<br><br>Findings:<br><br>During a review of Resident 23's Admission Record (Face Sheet), the face sheet indicated Resident 23 was admitted to the facility on [DATE] with diagnosis including Post traumatic stress disorder (PTSD- a mental health condition that's triggered by a terrifying event either experiencing it or witnessing it), depression (a depressed mood or loss of pleasure or interest in activities for long periods of time),unspecified atrial fibrillation (an irregular and often very rapid heart rhythm).<br><br>During a review of Resident 23's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 4/11/2024, indicated Resident 23's no speech and cognitive skills for daily decision-making were modified independence some difficulty in new situations only.<br><br>During an initial tour to the facility on [DATE] at 8:20 a.m. observed Resident 23 in bed, non-verbal.<br><br>During a concurrent interview on 5/19/2024 at 9:58 a.m. with the Director of Nursing (DON) and record review of Resident 23 care plan titled Trauma-informed care dated 4/10/2024, the DON stated the care plan doesn't indicate Resident 23 was assessed with regards to trauma and DON further added facility does not know what the triggers or history are. DON stated that none in Resident 23's medical record has a file of assessment for the trauma.<br><br>During an interview on 5/19/2024 at 1:30 p.m. with Licensed Vocational Nurse (LVN 6), LVN 6 stated that she was never trained or was never in-service for trauma informed care, LVN 6 said she is the nurse in charge of Resident 23, but she is not aware what are the triggers that can possibly re-traumatized him.<br><br>During an interview on 5/19/2024 at 4:24 p.m. with the Infection Preventionist/Director of Staff Development (DSD), the IP stated she just got the role of being the DSD and she did not do an in-service for trauma-informed care because she is also learning what needs to be done with the new position she acquired.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a record review of the facility's policy and procedure (P &P) titled Trauma Informed Care and Culturally Competent Care dated 08/2022, the P & P indicated to guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. All staff are provided in service training about trauma and trauma- informed care in the context of the healthcare setting. Nursing staff are trained on trauma screening and assessment tools. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028<br><br>Based on observation, interview, and record review, the facility failed to:<br><br>1.Ensure Licensed Vocational Nurse (LVN) 11 immediately enters the date and time of a controlled medication [a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction and may cause significant risk to patient safety]) administration, and her initials to Medication Administration Record ( MAR) and the Controlled Medication Sheet (a form used to document and track the administration of controlled substances for one of two sampled residents (Resident 16) per facility's policy and procedure ( P&P).<br><br>These deficient practices had the potential for increase in pain and/or uncontrolled pain, for Resident 16, medication errors and diversion (illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber) of narcotics (a medication used to relieve moderate to severe pain).<br><br>2. Ensure LVN's 11 and 12 did not administer Resident 16's Refresh Tears Ophthalmic Solution (medication for dry eyes) to Resident 139.<br><br>These deficient practices resulted in Resident 139 receiving medications that were not supplied to him, and placed Resident 16 at risk for mismanagement of her medication regimen, related to inaccurate documentation and/or non-reconciliation (the process of identifying the most accurate list of all medications that the patient is taking by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider) of their prescribed medications and/or controlled substances.<br><br>Findings:<br><br>a. During a review of Resident 16's Admission Record (Face Sheet), indicated Resident 16 was admitted to the facility on [DATE] with diagnoses including mononeuropathy (damage that happens to a single nerve [a bundle of fibers that receives and sends messages between the body and the brain], which results in loss of movement, sensation, or other function of that nerve) and pain due to internal orthopedic prosthetic devices (a medical device manufactured to replace a missing joint [part of the body where two or more bones meet to allow movement) or bone, or to support a damaged bone]).<br><br>During a review of Resident 16's History and Physical (H&P) dated 2/13/2024, the H&P indicated Resident 16 had the capacity to understand and make decisions.<br><br>During a review of Resident 16's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 2/15/2024, the MDS indicated Resident 16 had moderate cognitive (ability to think, understand, learn, and remember) impairment and was usually understood and usually understands others.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 16's Physician Order Summary Report dated 2/27/2024, indicated an order for Hydrocodone-Acetaminophen (narcotic pain medication) 10-325 milligrams ([mg] a unit of mass or weight) 1 tablet every four hours as needed for moderate pain.<br><br>During a concurrent observation and interview on 5/18/2024 at 7:27 a.m., with LVN 11, LVN 11 and LVN 2 doing an end of shift narcotic count of Resident 16's Hydrocodone-Acetaminophen medication LVN 11 stated Resident 16's-controlled medication count indicated there should be 17 tablets remaining. LVN 2 stated Resident 16's bubble pack count of Hydrocodone-Acetaminophen 10-325 mg indicated there was 16 tablets remaining and there was a discrepancy in the count. LVN 11 stated he forgot to document on the controlled medication count sheet that he gave Resident 16 Hydrocodone-Acetaminophen on 5/18/2024 at 3 a.m. LVN 11 then proceeded to document on the controlled medication count sheet that he administered Hydrocodone-Acetaminophen 10-325 mg 1 tablet on 5/18/2024 at 3 a.m.<br><br>During a continued observation, LVN 11 then proceeded to document in Resident 16's MAR that he administered Resident 16's Hydrocodone-Acetaminophen 10-325 1 tablet as administered.<br><br>During a review of Resident 16's Medication Administration Audit form dated 5/18/2024, indicated LVN 11 documented Hydrocodone-Acetaminophen 10-325 mg was administered to Resident 16 at 7:02 a.m., (four hours after the administration time of 3 a.m. and different from the controlled medication count sheet).<br><br>b. During a review of Resident 139's Face Sheet indicated Resident 139 was admitted to the facility on [DATE] with diagnoses including glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of the eye), cataract (a cloudy area in the lens [clear part] of the eye) and legal blindness.<br><br>During a review of Resident 139's H&P dated 5/7/2024, the H&P indicated Resident 139 had the capacity to understand and make decisions.<br><br>During a review of Resident 139's MDS, dated [DATE], indicated Resident 138 had moderate cognitive impairment and Resident 139 was usually understood by other and was usually able to understand others.<br><br>During a review of Resident 139's Physician Order Summary dated 5/8/2024 indicated an order for Refresh Tears Ophthalmic Solution administer four times a day (at 9 a.m., 1 p.m., 5 p.m., and 9 p.m.) for dry eyes.<br><br>During a review of Resident 139's Pharmacy Delivery Receipts dated 5/2024, indicated there was no documentation that Refresh Tears Ophthalmic Solution was delivered to the facility for Resident 139.<br><br>During a review of Resident 139's MAR dated 5/2024, indicated Refresh Tears Ophthalmic Solution was administered to Resident 139 on 5/9/2024 at 9 a.m. Continued review of Resident 139's MAR indicated Refresh Tears Ophthalmic Solution was administered to Resident 139 from 5/10/2024 to 5/13/2024 at 9 a.m. and 1 p.m. and from 5/15/2024 to 5/17/2024 at 9 a.m. and at 1 p.m. The MAR indicated licensed nurses documented that Refresh Tears Ophthalmic Solution was not available on 5/8/2024 and on 5/9/2024 at 1 p.m.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/18/2024 at 3:15 p.m., with LVN 2, LVN 2 stated from 5/11/2024 to 5/13/2024 at 9 a.m. and 1 p.m., and on 5/17/2024 at 9 a.m. and 1 p.m., Resident 139's Refresh Tears Ophthalmic Solution was missing from the medication cart and saw that another resident (Resident 16) received the same medication. LVN 2 stated he decided to administer Resident 16's medication to Resident 139 so Resident 139 would not miss his (Resident 139's) doses of Refresh Tears Ophthalmic Solution.<br><br>During an interview on 5/18/2024 at 3:35 p.m., with LVN 1, LVN 1 stated from 5/9/2024 at 9 a.m. and on 5/10/2024 at 9 a.m. and 1 p.m., Resident 139's Refresh Tears Ophthalmic Solution was missing from the medication cart and saw Resident 16 received the same medication (Refresh Tears Ophthalmic Solution). LVN 1 stated since Resident 16's medication came in single dose vials, it would be okay to give Resident 16's medication to Resident 139. LVN 1 stated Resident 139 was insisting on receiving his Refresh Tears Ophthalmic Solution, so he thought it was better to give Resident 16's medication to Resident 139. LVN 11 stated he made a mistake and had no explanation as to why he shared medications between Resident's 16 and 139.<br><br>During an interview on 5/19/2024 at 1:35 p.m. with the Director of Nursing (DON), the DON stated the correct steps in medication administration include pouring the medication, passing the medication to the resident and documenting that the medication was given. The DON stated the licensed nurses should never administer a resident's medications to another resident. The DON stated the moment the licensed nurse removes the controlled medication from the medication cart, they should document on the Controlled Medication Count Sheet. The DON stated after the licensed nurse administered the medication to the resident, the nurse should document the administration of the medication on the MAR before going to the next resident. The DON stated when pain medications were not administered as scheduled, and the administration time was not accurate, it had the potential for medication errors. The DON stated possible outcomes for not documenting in real time including increased the possibility of Resident 16 to not receive the medication to control the pain, placed the resident at risk of being overmedicated, and can also lead to medication diversion.<br><br>During a review of the facility's LVN Job Description (undated), indicated drug administration functions include to ensure that prescribed medication for one resident was not administered to another resident.<br><br>During a review of the facility's P&P titled, Preparation and General Guidelines for Controlled Substances, revised 1/2018, indicated when a controlled substance was administered, the licensed nurse immediately enters the date and time of control medication administration, the initials of the nurse administering the dose is completed after the medication was administered on the accountability record and the MAR.<br><br>During a review of the facility's P&P titled, Medication Administration-General Guidelines, revised 12/2019, the P&P indicated the licensed nurses must check the five rights prior to medication administration which include: right resident, right drug, right route, and right time. The P&P indicated a triple check to the five rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication is put away. The P&P indicated medications supplied for one resident are never administered to another resident.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled, Controlled Substances, revised 11/2022, the P&P indicated the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications.<br><br>During a review of the facility's P&P titled, Documentation of Medication Administration, revised 11/2022, the P&P indicated administration of medication is documented immediately after it is given. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident’s drug regimen must be free from unnecessary drugs.<br><br>45537<br><br>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 9), who was prescribed an anxiolytic (also known as anti-anxiety, a drug used to treat symptoms of anxiety such as feelings of fear, dread, uneasiness that may occur as a reaction to stress) for anxiety disorder was monitored for behavior of anxiety prior to administration of the medication and monitored for side effects and/or adverse reactions to the medication every shift.<br><br>This failure has the potential for Resident 9 to be unnecessarily medicated with anxiolytic (anti-anxiety medication) which could place Resident 9 high risk for adverse and/ or side effects that could negatively affect her overall health and well-being.<br><br>Findings:<br><br>During a review of Resident 9's Admission Record (face sheet), the Face sheet indicated Resident 9 was admitted at the facility on 3/1/2024 with diagnosis including anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness).<br><br>During a review of Resident 9's Medication Administration Record (MAR) dated 5/2024, the MAR indicated was prescribed Lorazepam (an anti- anxiety medication) 0.5 mg (a measure of weight equal to one thousandth of a gram) one tablet every twenty-four hours at night as needed for anxiety as manifested by verbalization of feeling anxious. The MAR did not indicate a behavioral monitoring for verbalization of feeling anxious was completed prior to administration of the anti- anxiety medication to Resident 9.<br><br>During a review of Resident 9's comprehensive care plan (CP, the CP did not indicate a plan of care was formulated for Resident 9 while taking the anti-anxiety medication.<br><br>During an interview and record review on 5/18/2024 at 4 p.m., Registered Nurse 1 (RN 1) stated Resident 9 was prescribed an anti-anxiety medication since 3/2024 and the MAR did not indicate Resident 9 was monitored for behavior of verbalization of feeling anxious prior to administration of the medication and did not indicate Resident 9 was monitored for side effects and adverse effects to the anti- anxiety medication every shift. RN 1 stated there was no plan of care formulated for Resident 9 who was taking an anti- anxiety medication. RN 1 stated a monitoring of the resident's behavior prior to administration of a psychotropic drug and monitoring of side effects and/ or adverse reaction to the medication should be documented every shift to identify if the resident will need adjustment of the medication.<br><br>During an interview on 5/19/2024 at 2:58 p.m., the Director of Nursing Services (DON) stated behavior monitoring and identification of the side effects and adverse reactions are necessary to determine if the psychotropic medication is effective or not and if so, a re-evaluation should be done to meet the residents' needs.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's Policy and Procedure (P/P) on Psychotropic Medication Management undated, the P/P indicated the residents in need of psychotherapeutic medications receive appropriate assessment and interventions to achieve their highest practicable level of functioning. The P/P indicated medication effects will be monitored and documented on the medication administration record, to include targeted behavior monitoring, and monitoring for adverse effects when the medications are used. |

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| | 555805 | A. Building<br>B. Wing | 05/20/2024 |

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| Bel Vista Healthcare Center | 5001 East Anaheim Street<br>East Long Beach, CA 90804 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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** 45028<br><br>Based on observation, interview, and record review, the facility failed to:<br><br>1. Ensure medication carts (a moveable (a movable piece of equipment used in healthcare facilities to store, transport, and dispense medicines, medical supplies, and emergency equipment) 1, 2, and the facility's intravenous ([IV] giving medicines or fluids through a needle or tube inserted into a vein) medication carts were locked when unattended.<br><br>This deficient practice resulted in resident's, visitors, and other staff having immediate access to medications and had the potential for theft, loss, and unauthorized consumption of medications.<br><br>2. Ensure the medication cart 2 keys were left unattended on top of medication cart 2.<br><br>These deficient practices resulted in resident's, visitors, and other staff having immediate access to narcotics and had the potential for theft, loss, drug diversion (the illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber), and unauthorized consumption of medications.<br><br>3. Ensure Resident 10's opened Vancomycin (medication used to treat bacterial infections) 50 milligrams ([mg] a unit of mass or weight)/milliliters ([mL] a metric unit of volume) Solution and Resident 15's opened Acetylcysteine (medication used to decrease mucous in patients with certain lung conditions) 10% Solution stored in the refrigerator were labeled with an open date per the facility's policy and procedure (P&P) titled Medication Storage in the Facility.<br><br>This deficient practice of failing to label medications per the facility's P&P increased the risk of Residents 10 and 15 to have received medications that had become ineffective or toxic due to improper labeling possibly leading to health complications resulting in hospitalization and death.<br><br>Findings:<br><br>1. During an observation on 5/18/2024 at 6:42 a.m., in the facility hallway, there were two unlocked and unattended medication carts and one unlocked and unattended IV cart.<br><br>During an interview on 5/18/2024 at 6:58 a.m., with Licensed Vocational Nurse (LVN) 11, LVN 11 stated the medication carts were unlocked. LVN 11 stated the medication carts were unlocked because the lock button was popped out and the drawers can be opened. LVN 11 stated medication carts should be locked prior to stepping away from them.<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 - Many | During a review of the facility's P&P titled, Storage of Medications, revised 11/2020, the P&P indicated drugs and biologicals in the facility are stored in locked compartments. The P&P indicated the nursing staff was responsible for maintaining medication storage and preparation in a clean, safe, and sanitary manner. The P&P indicated compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in used and unlocked medication carts are not left unattended.<br><br>2. During an observation on 5/18/2024 at 6:56 a.m., in the facility hallway, there was keys left unattended on top of medication cart 2.<br><br>During an interview on 5/19/2024 at 7:01 a.m., with LVN 11, LVN 11 stated the keys belonged to medication cart 2. LVN 11 stated he accidentally left the keys on top of medication cart 2. LVN 11 stated he should have made sure the keys remained with him until the medication count was completed with the incoming shift.<br><br>During a review of the facility's P&P titled, Storage of Medications, revised 11/2020, the P&P indicated only persons authorized to prepare and administer medications have access to locked medications.<br><br>During a review of the facility's P&P titled, Controlled Substances, revised 11/2022, the P&P indicated the charge nurse on duty maintains the keys to controlled substance containers.<br><br>3. a. During a review of Resident 10's Admission Record (Face Sheet), the Face Sheet indicated Resident 10 was originally admitted to the facility on [DATE] with diagnoses including acute respiratory failure (often caused by a disease or injury that affects breathing) and enterocolitis (inflammation [swelling] that occurs in the intestines) due to clostridium difficile (a bacteria which causes an infection of the colon [longest part of the large intestine]).<br><br>During a review of Resident 10's Minimum Data Set ([MDS] a standardized assessment and care-screening tool) dated 3/28/2024, the MDS indicated Resident 10's cognition (ability to think, understand, learn, and remember) was moderately impaired and sometimes had the ability to be understood and sometimes understood others.<br><br>During a concurrent observation and interview on 5/18/2024 at 7:53 a.m., of the facility's medication refrigerator, with LVN 2, observed Vancomycin 50 mg/mL solution with no open date label. LVN 2 stated the medication should be labeled with open date.<br><br>b. During a review of Resident 15's Admission Record (Face Sheet), indicated Resident 15 was admitted to the facility on [DATE] with diagnoses including acute (develops suddenly) and chronic (develops slowly and may worsen over an extended period) respiratory failure (a serious condition which makes it difficult to breathe on your own).<br><br>During a review of Resident 15's MDS dated [DATE], the MDS indicated Resident 15's cognitive skills for daily decision making were severely impaired and was rarely able to understand and be understood by others.<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 - Many | During a concurrent observation and interview on 5/18/2024 at 7:53 a.m., of the facility's medication refrigerator, with LVN 2, Acetylcysteine 10% solution was observed with no opened date labeled. LVN 2 stated the medication should be labeled with open date.<br><br>During an interview with the Director of Nursing (DON) on 5/19/2024 at 1:35 p.m., the DON stated, when the licensed nurses open a new multi-dose medication, they must be labeled with open date and expiration date on the medication. The DON stated if there was no opened date on the medication licensed nurses can potentially administer expired medications to the resident which could result in a change of condition and unnecessary hospitalization . The DON stated if the medication cart was left unlocked and the keys are left on top of the cart, everyone in the building had access to the medications including narcotics in the cart. The DON stated there was a potential for the residents, staff, or visitors to take the medications from the cart and possibly consume the medications or drug diversion could occur. The DON stated if a resident consumed medications that were not prescribed to them, it can potentially lead to complications including change of condition which could possibly require hospitalization and/or death from overconsumption of medications.<br><br>During a review of the facility's P&P titled, Medication Storage in the Facility, revised 1/2018, the P&P indicated when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The P&P indicated the nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. |

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| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.<br><br>45028<br><br>Based on interview and record review the facility failed to ensure laboratory findings was relayed to medical doctor (MD) when available for one of one sampled residents ( Resident 6).<br><br>This deficient practice has the potential to miss abnormal laboratory to be relayed to MD and informed for any abnormal findings.<br><br>Findings:<br><br>During a record review of Resident 6's Admission record, the admission record indicated Resident 6 was admitted to the facility initially on 2/24/2024. Resident 6's diagnosis included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), generalized muscle weakness (a decrease in muscle strength) and paroxysmal atrial fibrillation (happens when abnormal electrical impulses suddenly start firing in the atria).<br><br>During a record review of Resident 6's Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 3/1/2024, the MDS indicated Resident 6 supervision on eating at required dependent assistance (helper does all the effort) from the two or more staff for transfer, putting on/off taking off footwear, toileting and shower/ bathe self, and lower body dressing.<br><br>During a record review of Resident 6's telephone order (TO), dated 5/8/2024, the TO indicated monthly laboratory complete blood count (CBC- a blood test that measures many different parts and features of your blood) and basic metabolic panel (BMP- is a blood sample test that measures eight different substances in your blood).<br><br>During a record review of the Laboratory result, basic metabolic panel (BMP- is a blood sample test that measures eight different substances in your blood) B-type Natriuretic Peptide(BNP- Brain natriuretic peptide (BNP) test is a blood test that measures levels of a protein called BNP that is made by your heart and blood vessels.), complete blood count (CBC a laboratory test which gives information about the production of all blood cells in the body dated 5/10/2024, collection date 5/10/2024, received date 5/10/2024.<br><br>During an interview on 5/18/2024 at 1:20 p.m. with the Registered Nurse 1(RN1), the RN1 stated that laboratory comes in Monday, Wednesday, and Friday since this is a small facility. RN1 stated that the family requested to get the laboratory, but the MD and family member should be informed as soon as the laboratory result is available. RN1 stated it is important to get the family involved and the MD to better take care of the Resident.<br><br>During a concurrent interview with Registered Nnurse (RN )1 at 5/18/2024 at 2:01 p.m. and record review of Resident 6's laboratory result, RN1 stated that the order was done 5/10/2024 and was received on that day, it was not relayed to MD until 5/10/2024, RN1 stated normal or abnormal laboratory result should be relayed to MD and also if the family wishes to know what the result, they have the right to be inform as well. RN1 stated it was relayed to MD on 5/13/2024 and the laboratory result was received on 5/10/2024.<br><br>(continued on next page) |

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| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/19/2024 at 9:58 a.m. with the Director of Nursing (DON), the DON stated the laboratory results whether it is normal or abnormal needs to be relayed to MD as soon as it is available, Resident 6's laboratory was not relayed on time, it was resulted on 5/10/2024 and MD was notified on 5/13/2024.<br><br>During a review of the facility's P&P titled, Lab and Diagnostic Test Results - Clinical Protocol, revised 11/2018, the P&P indicated the staff will process test requisitions and arrange for tests. The P&P indicated direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable. The P&P indicated a physician should respond within one hour regarding a lab test result requiring immediate notification. The P&P indicated if the attending or covering physician does not respond to immediate notification within an hour, the nursing staff should contact the Medical Director for assistance. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>45537<br><br>Based on observation, interview and record review, the facility failed to ensure the walk-in freezer in the facility's kitchen did not have an ice buildup.<br><br>This failure has the potential for the residents' food supply to be tampered and/or contaminated that could put the residents at risk for food-borne illnesses.<br><br>Findings:<br><br>During an observation of the facility's walk-in freezer on 5/18/2024 at 6:48 a.m., the freezer had an ice build-up at the top portion of the freezer.<br><br>During an interview on 5/18/2024 at 6:48 a.m., [NAME] 1 (CK 1) stated the ice buildup was concerning because it might leak and can destroy the residents' food supply.<br><br>During an interview on 5/18/2024 at 2:01 p.m., the Maintenance Director (MD) stated the ice condensation in the freezer was normal because it was an old freezer that needed an insulation line to be redone.<br><br>During an interview and record review on 5/18/2024 at 2:28 p.m., the Registered Dietician (RD) stated the ice buildup in the walk-in freezer has been identified and noted during kitchen audits and was fixed/ resolved by the facility's maintenance several times. RD stated the buildup is not ideal but the risk for contamination is minimal.<br><br>During an interview on 5/20/2024 at 9:34 a.m., the Administrator stated the ice condensation in the walk-in freezer has been addressed and if the same situation occurs, the facility will install a new freezer in the kitchen.<br><br>During a review of the facility's Policy and Procedure (P/P) on Food Receiving and Storage revised 11/ 2022, the P/P indicated the facility shall receive and store the residents' food supply in a manner that complies with safe food handling practices. The P/P indicated functioning of refrigeration should be monitored daily and throughout the day by the food and nutrition services manager or designee to ensure food is not stored under leaking water lines or under lines on which the water has condensed. |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906<br><br>Based on interview and record review, the facility failed to address/ implement facility assessment elements when:<br><br>a.The facility failed to include the Infection Prevention Nurse (IPN) during the resident's assessment in the facility's assessment dated ,d+[DATE]/ 2024 for the population of 39 census.<br><br>b.The facility failed to assess needs for Resident that will be admitted to the facility with trauma experience to be able to provide needs and necessary care needed.<br><br>These deficient practices had a potential to result in the provision of inadequate care and services to the facility's resident population.<br><br>Findings:<br><br>A. During a record review of the facility's assessment provided on 5/18/2024 during entrance conference, the assessment did not indicate that IPN was included in the facility wide assessment that was conducted on 1/30/2024.<br><br>During a concurrent interview on 5/20/2024 at 9: 46 a.m. with the DON and Admin and record review of the facility assessment, the Admin stated that he forgot to include the IPN on the person(s) involved in completing the assessment. The Admin stated IPN role is important since there is a lot of infectious diseases and Residents in the facility are immunocompromised and vulnerable.<br><br>B. During a review of Resident 23's Admission Record (Face Sheet), the face sheet indicated Resident 23 was admitted to the facility on [DATE] with diagnosis including Post traumatic stress disorder (PTSD- a mental health condition that's triggered by a terrifying event either experiencing it or witnessing it), depression (a depressed mood or loss of pleasure or interest in activities for long periods of time), unspecified atrial fibrillation (an irregular and often very rapid heart rhythm).<br><br>During a review of Resident 23's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 4/11/2024, indicated Resident 23's no speech and cognitive skills for daily decision-making were modified independence some difficulty in new situations only.<br><br>During an entrance conference on 5/18/2024 at 8:54 a.m. with the Director of Nursing (DON), the DON stated that she was present with the rest of the governing body when they did the facility assessment. DON stated that facility assessment is important to make sure identify residents need and resources will be available if needed. DON stated that the facility has one resident that is experiencing Post traumatic Disease that was identified and was verbalized by his significant other.<br><br>During a record review of the facility's Resident matrix printed 05/18/2024, the Matrix indicated that Resident 23 who resides at room [ROOM NUMBER]-A has PTSD or trauma (a deeply distressing or disturbing experience).<br><br>(continued on next page) |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/202024 at 10:04 a.m. with the DON and Administrator (Admin), The Admin stated that there is no PTSD diagnosis included under the assessment category of the psychiatric/mood disorder. The Admin stated that it is important to update and revised to reflect the resident diseases and condition to be able to manage the needed care.<br><br>During a record review of the facility's policy and procedure(P&P) dated 12/2023 titled Facility Assessment, the P & P indicated a facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during say to day operations. Facility wide assessment to ensure that the resources are available to meet the specific needs of our residents. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028<br><br>Based on interview and record review, the facility failed to ensure the Medication Administration Record ([MAR] a record of all medications administered to a resident) were accurately documented for the month of 5/2024 for two of two sampled residents (Resident 18 and 139). Licensed nurses documented:<br><br>1. For Resident 18, Licensed Vocational Nurse (LVN) 10 documented on Resident 18's MAR as administered for Ipratropium-Albuterol Solution (a medication used to open bronchial tubes [air passages]) every six hours for shortness of breath (unable to breathe normally), on 5/17/2024 at 9 p.m., and on 5/18/2024 at 3 a.m., when the medication was not delivered in the facility.<br><br>This deficient practice placed Resident 18 at risk for further respiratory complications, change of condition, and unnecessary hospitalization from lack of treatment.<br><br>2. For Resident 139, licensed nurses documented on Resident 139's MAR as administered for Refresh Tears Ophthalmic Solution ([Carboxymethlcellulose Sodium]- medications used for dry eyes) four times a day from 5/8/2024 to 5/13/2024 for the 5 p.m. and 9 p.m. dose, and dose from 5/15/2024 to 5/17/2024 for the 5 p.m. and 9 p.m. dose when the medication was not delivered in the facility.<br><br>These deficient practices of failing to ensure the medical records accurately reflect care delivered to the resident increased the risk Residents 18 and 139 to not received their medications as ordered and may have received unnecessary dosage adjustments to their medications possibly resulting in medical complications and a decreased quality of life.<br><br>Findings:<br><br>a. During a review of Resident 18's Admission Record (Face Sheet) indicated Resident 18 was admitted to the facility on [DATE] with diagnosis including congestive heart failure ((heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), acute respiratory failure (a serious condition which makes it difficult to breathe on your own), and chronic pulmonary edema (a condition in which fluid builds up in the lungs, making it difficult to breathe).<br><br>During a review of Resident 18's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/28/2024, the MDS indicated Resident 18 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 18 was sometimes understood by others and sometimes understood others.<br><br>During a review of Resident 18's Physician Order Summary Report dated 5/17/2024 indicated Resident 18 was to receive Ipratropium-Albuterol Solution 0.5-2.5 (3) milligrams ([mg] a unit of mass or weight)/3 milliliters ([mL] a unit of capacity) every six hours (3 a.m., 9 a.m., 3 p.m., and 9 p.m.) for three days for shortness of breath and wheezing (a high-pitched whistling sound made while breathing, associated with difficulty breathing).<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 18's Pharmacy Delivery Receipts, from 5/1/2024 through 5/18/2024, indicated there was no documentation that Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3 mL was delivered to the facility for Resident 18.<br><br>During a review of Resident 18's MAR, for the month of 5/2024, indicated Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3 mL was administered to Resident 18 on 5/17/2024 at 9 p.m., and on 5/18/2024 at 3 a.m. Continued review of Resident 18's MAR indicated licensed nurses documented that Ipratropium-Albuterol 0.5-2.5 0.5-2.5 (3) mL was not available from the pharmacy on 5/18/2024 at 9 a.m. and at 3 p.m. The MAR indicated Resident 18 received two doses of Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3 mL from 5/17/2024 to 5/18/2024 when the medication was not available in the facility.<br><br>During an interview on 5/18/2024 at 4:48 p.m., with LVN 10 stated she documented that she administered Ipratropium-Albuterol Solution to Resident 18 on 5/17/2024 at 9 p.m., LVN 1 stated she was probably in a hurry and did not verify the Ipratropium-Albuterol Solution was in the medication cart prior to documenting she administered it to Resident 18.<br><br>b. During a review of Resident 139's Admission Record (Face Sheet) indicated Resident 139 was admitted to the facility on [DATE] with diagnoses including glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of the eye), and cataract (a cloudy area in the lens [clear part] of the eye) and legal blindness.<br><br>During a review of Resident 139's History and Physical (H&P) dated 5/7/2024, the H&P indicated Resident 139 had the capacity to understand and make decisions.<br><br>During a review of Resident 139's MDS, dated [DATE], indicated Resident 138 had moderate cognitive impairment and Resident 139 was usually understood by other and was usually able to understand others.<br><br>During a review of Resident 139's Physician Order Summary Report, dated 5/8/2024 indicated an order for Refresh Tears Ophthalmic Solution four times a day (9 a.m., 1 p.m., 5 p.m., and 9 p.m.) for dry eyes was ordered on 5/8/2024.<br><br>During a review of Resident 139's Pharmacy Delivery Receipts from 5/1/2024 through 5/18/2024, indicated there was no documentation that Refresh Tears Ophthalmic Solution was delivered to the facility for Resident 139.<br><br>During a review of Resident 139's MAR for 5/2024, indicated Refresh Tears Ophthalmic Solution was administered to Resident 139 from 5/8/2024 to 5/13/2024 at 5 p.m. and at 9 p.m., and from 5/15/2024 to 5/17/2024 at 5 p.m. and at 9 p.m. Continued review of Resident 139's MAR indicated licensed nurses documented that Refresh Tears Ophthalmic Solution was not available on 5/8/2024 and on 5/9/2024 at 1 p.m. The MAR indicated Resident 139 received 18 doses of Refresh Tears Ophthalmic Solution from 5/7/2024 to 5/13/2024 and from 5/15/2024 to 5/17/2024 when the medication was not available in the facility.<br><br>(continued on next page) |

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|---|---|---|---|
| | 555805 | A. Building<br>B. Wing | 05/20/2024 |

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|---|---|
| Bel Vista Healthcare Center | 5001 East Anaheim Street<br>East Long Beach, CA 90804 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/18/2024 at 9:05 a.m., with Resident 139 stated there were several days when he gets a different number of pills when he received his medication and does not consistently get his eye drops. Resident 139 stated the number of medications the nurses give him are never the same and sometimes give him the wrong medications. Resident 139 stated, when he asked licensed nurses to explain what the medications were that they were giving him and why the number of pills were inconsistent, and they (the licensed nurses) were not able to explain. Resident 139 stated when he asked the licensed nurses where his eyedrops were, the licensed nurses tell him it has not arrive from the pharmacy. Resident 139 stated his eyes have been burning and feel like he has sand in his eyes because his eyes are so dry from not receiving the eye drops but the nurses were not doing anything about it.<br><br>During a concurrent observation and interview on 5/18/2024 at 9:29 a.m., with LVN 2, checked Station 1's medication cart (movable piece of equipment used in healthcare facilities to store, transport, and dispense medicines, medical supplies, and emergency equipment), LVN 2 stated there was no Refresh Tears Ophthalmic Solution for Resident 139 in the medication cart.<br><br>During an interview on at 4:21 p.m., with LVN 6 stated she signed Resident 139 MAR that she administered the 5 p.m. and 9 p.m. doses of Refresh Ophthalmic Solution to Resident 139 from 5/8/2024 to 5/12/2024 and from 5/15/2024 to 5/17/2024 when she did not physically administer it to him (Resident 139).<br><br>During an interview on 5/19/2024 at 8:38 p.m., the Director of Nursing (DON) stated the correct way to prepare medications for administration is to take the medication cart to the resident's doorway, verify using the resident's MAR with the medications ordered, prepare the medications, identify the correct resident, administer the medication to the resident, and document the medication as given. The DON stated the licensed nurses should not document on the MAR that medications as given when they (licensed nurses) have not actually administered the medications to the residents. The DON stated if residents do not get their medications as prescribed, the residents are at risk for adverse reactions (a harmful and undesired effect resulting from a medication) including respiratory complications, increased eye discomfort and pain, which could potentially lead to hospitalization s.<br><br>During a review of the facility's LVN Job Description (undated), indicated the LVN's essential duties include preparing and administering medications as ordered by the physician.<br><br>During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, revised 12/2019, indicated prior to administration of any medications, the medication and dosage schedule on the resident's MAR are compared with the medication label. The P&P indicated medications are administered in accordance with written orders of the prescriber. The P&P indicated the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. The P&P indicated at the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>43906<br><br>Based on interview and record review, the facility's Quality Assessment and Assurance ([QAA] to develop and implement appropriate plans of action to correct identified quality deficiencies) and Quality Assurance Performance Improvement ([QAPI] designated to bring about constant and measurable improvement in the services provided at the facility for continual improvement of quality care) committee failed to:<br><br>1.Maintain effective systems in place to obtain and use feedback for facility issues submitted by direct care staff, residents, and resident representatives with regards to trauma informed care.<br><br>2. Monitor, review and analyze data for performance improvement of facility issues such as Abuse, use of side rails or bed against the wall, and change of condition.<br><br>These deficient practices have the potential to not identify systematic approach to improve services to the residents.<br><br>Findings:<br><br>During a concurrent interview and record review on 5/20/2024 at 11:06 a.m. with the Administrator (ADMIN) and Director of Nursing (DON), the ADMIN stated the facility does not have any evidence of monitoring facility issues. The ADM stated he does not have any logs to track and trend facility issues to see what is working but they should have a process in place. The ADMIN added that everyday head department makes their rounds and fix it as soon as it was identified. The Admin stated the facility is not following the QAPI policy for developing, monitoring, and evaluating performance indicators.<br><br>During a review of the facility's titled QAPI program Plan, the QAPI plan dated 11/17/2023 evaluation indicated that the Administrator to conduct a trend opportunities and changes on all identified findings. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906<br><br>Based on interview and record review, the facility failed to ensure resident that is taking antibiotic vancomycin (can treat infections) 125 mg oral suspension for Clostridioides difficile (c-diff- is a bacterium that causes an infection of the colon, the longest part of the large intestine) was discontinued from contact isolation and was not placed in enhanced precaution for one of one sample Resident (Resident 38)<br><br>This deficient practice had the potential for other Residents to get infected while Resident 38 is still on antibiotic without precaution.<br><br>Findings:<br><br>During a review of Resident 38's Admission Record (Face Sheet), indicated Resident 38 was admitted to the facility on [DATE] with diagnosis including type 2 diabetes mellitus, cancer of the kidney (abnormal growth of cells in your body tissue), and gastrostomy tube ([GT] soft flexible tube surgically placed into the stomach through the abdominal wall to provide nutrition and/or medication).<br><br>During a review of Resident 38's History and Physical (H&P), dated 3/14/2024, indicated Resident 38 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 38's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 2/3/2024, indicated Resident 38 had moderate cognitive (ability to think, understand, learn, and remember) skills for daily decision-making impairment. The MDS indicated Resident 38 had unclear speech (slurred or mumbled words) and was usually understood and was usually able to understand others.<br><br>During a record review of the order summary report (OSR) dated 1/30/2024, the OSR indicated Resident 38 on strict single room isolation with contact precautions due to c-diff positive.<br><br>During a record review of the order summary report (OSR) dated 1/31/2024, the OSR indicated Resident 38 on Vancomycin 125 mg via Gastrostomy Tube (GT a tube inserted through the belly that brings nutrition directly to the stomach) until 2/10/2024.<br><br>During a concurrent interview on 5/19/2024 at 2:16 p.m. with the Infection Preventionist (IP) and record review of the infection prevention notes, the IP stated she discontinued the isolation for Resident 38 on 2/8/2024 because Resident 38 did not have any signs and symptoms of diarrhea and there is no order for enhanced precaution. IP stated direct care staff {(Certified Nurse Assistant (CNA) and License Vocational Nurse (LVN)} are not wearing any PPE when providing care that are not on isolation.<br><br>During a record review of the facility's policy and procedure (P&P) titled Surveillance for Infections dated 2017, the P & P indicated if transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, The IP will collect data to help determine the effectiveness of such measures. |

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| F 0912<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906<br><br>Based on observation, interview, and record review, the facility failed to ensure two of 20 residents bedrooms measured at least 80 feet square feet (sq. ft) per resident in rooms [ROOM NUMBERS].<br><br>The deficient practice resulted in reduced, required bed space per resident in rooms [ROOM NUMBERS], and had the potential for inadequate space during resident's care, or the inability for residents' access and use of personal assistive devices, furniture and providing enough space for visitors.<br><br>Findings:<br><br>During an initial tour on 5/18/2024 at 6:45 a.m., during the initial tour of the facility-and during the entrance conference with the Infection Preventionist, the IP stated that she is aware there is a room waiver.<br><br>During a tour with the Administrator on 5/19/2024 at 11:03 a.m. stated rooms [ROOM NUMBERS] had been granted a waiver (variation) in December 2021.<br><br>During a review of the facility's Client Accommodation s Analysis form dated 5/18/2024, the form indicated the following:<br><br>Room: Sq ft. Number of Residents<br><br>5 149.80 2<br><br>6 149.80 2<br><br>During an interview on 5/19/2024 at 9:28 a.m. with Certified Nurse Assistant (CNA)4, CNA 4 stated that it is difficult to maneuver the Hoyer (a patient lift used by caregivers to safely transfer patients) lift in both room, CNA 4 stated that if there is a resident that needs all the equipment and needs extensive to total assistance with 2 staff it is really difficult to provide Activities of Daily Living(ADL's) so Residents are left in the bed.<br><br>During observations on 5/18/2024, 5/19/2024, and 5/20/2024, there was not enough space for the nursing staff to provide care and services the residents and there were no complaints received from the residents regarding room size for rooms [ROOM NUMBERS].<br><br>During an interview and concurrent record review on 5/19/2024 at 10:20 a.m. with the Administrator and Maintenance Supervisor (MS), Admin stated that granting of the room variance will not adversely affect the resident's health and safety and the waiver was in accordance with the special needs of the residents. The Admin stated that he would put resident that in need of total assistance in the A bed instead of B bed to accommodate residents need. |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>43906<br><br>Based on observation, interview and record review, the facility failed to ensure the caregivers of one of one sampled resident (Resident 32) were properly identified through background check, competencies verified and provided orientation of the facility's rules and regulations before allowed to render care for one of one sampled resident (Resident 32).<br><br>This failure had the potential for Resident 32 to be provided assistance and care not in line with the professional standard of care that could negatively affect her safety and well-being.<br><br>Findings:<br><br>During a review of Resident 32's Admission Record (Face sheet), the face sheet indicated Resident 32 was admitted at the facility on 4/9/2024 with a diagnosis including anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) and senile degeneration of the brain (a condition when older individuals suffer from cognitive decline particularly memory loss).<br><br>During a review of Resident 32's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 4/12/2024, the MDS indicated Resident 32 had severe disorientation and was unable to make independent decisions and was dependent to two or more persons assist to complete her activities of daily living ({ADL}) such as dressing, bathing, hygiene, and toileting.<br><br>During a review of Resident 32's Physician Orders dated 5/8/2024, the primary doctor ordered the following:<br><br>a. regular diet with thin liquids consistency,<br><br>b. monitor intake and output every shifty for 30 (thirty) days,<br><br>c. monitor episodes of refusing tuning and repositioning every shift,<br><br>d. out of bed as tolerated,<br><br>e. Monitor for pain every shift using pain scale, and<br><br>f. wheelchair mobility.<br><br>During an observation on 5/19/2024 at 5:45 p.m., Resident 32 was sitting on her bed while a caregiver (identification unknown) was assisting Resident 32 with spoonful of food at varied intervals during dinner.<br><br>(continued on next page) |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview and record review on 5/19/2024 at 7 p.m., the Director of Staff Development (DSD) or Infection Preventionist (IP), DSD stated the family of Resident 32 provided Resident 32's caregivers but there is no physician order for a private caregiver and/ or sitter for Resident 32. DSD stated she contacted the marketer and the marketer stated there is no contract for the company who provided 1:1 caregiver. DSD added she did not have the caregivers' background check and competencies verified before allowing them to render care to Resident 32.<br><br>During an interview and record review on 5/19/2024 at 7:40 p.m., Registered Nurse 1 (RN 1) stated and confirmed there was no facility orientation provided for the caregivers and she did not have a checklist started and/or on file. RN 1 stated it was a health and safety risk for Resident 32.<br><br>During an interview on 5/19/2024 at 7:45 p.m., the Director of Nursing Services (DON) stated she believed the facility could have reached out to the company who provided the caregivers to Resident 32 to initially provide the background checks and verified competencies of the caregivers.<br><br>During an interview on 5/19/2024 at 7:56 p.m., the Administrator (OM) stated the facility did not have specific contract with the company who provided the caregivers to Resident 32. The OM stated these caregivers should have been background checked and their nursing assistant training verified before allowed in the facility. The OM stated it is his and all department head staff responsibility to ensure the residents, staff and visitors are safe in the facility.<br><br>During a review of the facility's Policy and Procedure (P/P) on Staffing, Sufficient and Competent Nursing revised 8/2022, the P/P indicated the nurse aides/nursing assistants providing nursing or related services to residents in the facility, including those who provide services through an agency or under contract with the facility must possess appropriate skills and competencies to provide nursing and related care and services for all residents in accordance with resident care plans and facility assessment.<br><br>During a review of the facility's Policy and Procedure (P/P) on Nurse Aide Registry Verification revised 8/2022, the P/P indicated the certified nurse aide licenses shall be verified through the state registry of the nurses' aides before individuals may serve as nurse aides or nursing assistants. The P/P indicated the human resource director or designee is responsible for contacting the state nurse aide registry to determine the validity of the individual's certification status including other documents and information necessary concerning the individual<br><br>45537 |