

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555852	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Park Avenue Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1550 North Park Avenue Pomona, CA 91768	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38108</p> <p>Based on observation, interview, and record review, the facility failed to ensure privacy, for one of one sampled resident (Resident 60), was maintained. During initial tour of the facility, on 7/8/2024, Resident 60's privacy curtain remained partially opened and Resident 60's genitals and lower part of the body was exposed while Resident 60 received care.</p> <p>This deficiency resulted in violating Resident 60's right to privacy and dignity and had the potential to result in a decline in psychosocial well-being.</p> <p>Findings:</p> <p>During a review of Resident 60's Admission Record (AR), the AR indicated Resident 60 was admitted to the facility on [DATE] with diagnosis that included Dementia (a decline in mental ability severe enough to interfere with daily life), Alzheimer's Disease (a progressive disease that causes memory loss and other mental functions) and muscle weakness.</p> <p>During a review of Resident 60's History and Physical (H&amp;P), dated 8/18/2023, indicated resident 60 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 60's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 5/29/2024, the MDS indicated Resident 60 sometimes made self-understood and usually understood others. The MDS indicated Resident 60 was totally dependent (helper does all the effort) with toileting and personal hygiene, upper and lower body dressing, and with sitting to lying position.</p> <p>During an observation on 7/8/2024 at 8:54 AM, Resident 60 was observed lying in bed and Certified Nurse Assistant 3 (CNA 3) was performing peri-care (washing the genitals [sexual organs located outside of the body] and anal [end of large intestine, allows feces to come out] area). Resident 60's privacy curtain was left partially open and Resident 60's stomach, genitals, and lower part of the body were exposed and were seen through the opening of the curtain.</p> <p>During an interview with CNA 3, on 7/8/2024 at 8:55 AM, CNA 3 stated Resident 60's privacy curtain was left open and I am supposed to close the curtain more (fully close) for the privacy of the resident, for the dignity.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Quality Assurance Nurse (QAN), on 7/11/2024 at 2:52 PM, the QAN stated privacy curtains should be fully closed for resident privacy and dignity. The QAN stated privacy was important because it was the resident's right (in general) to receive privacy and was also a dignity violation.</p> <p>During a review of the facility's policy titled Resident Rights, revised 1/1/2012, the P&amp;P indicated to promote and protect the right of all residents at the facility. Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of resident rights. State and federal laws guarantee certain basic rights to all residents of the facility. These rights included .privacy and confidentiality.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 48 and Resident 109) had their call lights within reach.</p> <p>This failure had the potential to result in Residents 48 and 109 not to receive care and services timely.</p> <p>Findings:</p> <p>a. During a review of Resident 48's Admission Record (AR), the AR indicated Resident 48 was admitted to the facility on [DATE] with diagnoses including but not limited to transient cerebral ischemic attack (TIA- a temporary blockage of blood flow to the brain), hemiplegia (weakness to one side of the body), anxiety (a feeling of worry, dread, and uneasiness), bipolar disorder (serious mental illness that causes unusual shifts in mood).</p> <p>During a review of Resident 48's Minimum Data Set (MDS- a comprehensive standardized assessment and screening tool), dated 5/9/2024, the MDS indicated Resident 48's cognition (ability to understand and process information) was moderately impaired.</p> <p>During a review of Resident 48's History and Physical, dated 7/12/2024, the H&amp;P indicated Resident 48 had fluctuating ability to make Resident 48's own decisions.</p> <p>During a concurrent interview and observation on 7/8/2024 at 9:26 AM in Resident 48's room with Registered Nurse 2 (RN 2). Resident 48 stated, I cannot reach the call light. The call light was observed with cord attached to the wall and located on the right side of Resident 48's bed. RN 2 stated, the call light should not be clipped to the wall and needed to be kept within Resident 48's reach. RN 2 stated in case Resident 48 needed assistance Resident 48 had access to the call light.</p> <p>During an interview on 7/11/2024 at 3 PM, with the Director of Nursing (DON), the DON stated, the call light should always be kept within reach of Resident 48 while Resident 48 was in bed, it's our policy. The DON stated, it was important to have the call light within reach to ensure residents (in general) were able to call for assistance when assistance [from staff] was needed.</p> <p>36924</p> <p>b. During a review of Resident 109's Admission Record (AR), the AR indicated Resident 109 was readmitted to the facility on [DATE] with diagnoses that included cerebral infarction (disruption of blood flow and damage to tissues in the brain due to a loss of oxygen to the area), chronic obstructive pulmonary disease (COPD, long standing group of diseases that cause airflow blockage and breathing-related problems, make it difficult to breathe), and heart failure (condition in which the heart cannot pump enough blood to all parts of the body).</p> <p>During a review of Resident 109's History &amp; Physical (H&amp;P), dated 2/5/2024, the H&amp;P indicated Resident 109 did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 109's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 4/25/2024, the MDS indicated Resident 109 had severe cognitive (ability to understand and process information) impairment and required substantial/maximal assistance with lower and upper body dressing, putting on/taking off footwear, and supervision or touching assistance with toileting and when walking 10 and 150 feet.</p> <p>During a concurrent observation and interview, on 7/8/2024, at 10:02 AM, Resident 109 stated Resident 109 didn't know where Resident 109's call light was. Resident 109's call light was observed on the floor, on the right side of Resident 109's bed, and not within Resident 109's reach.</p> <p>During a concurrent observation and interview with Certified Nurse Assistant 7 (CNA 7), on 7/8/2024, at 10:11 AM, CNA 7 stated Resident 109 could not reach the call light and stated Resident 109's call light was on the floor. CNA 7 stated it was important for Resident 109's call light to be within reach so Resident 109 can call us [staff].</p> <p>During a review of Resident 109's High Risk for Injury/Fracture Care Plan, dated 7/2/2024, the High Risk for Injury/Fracture Care plan indicated to keep call light within reach.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Communication-Call System revised on 1/1/2012, the P&amp;P indicated Call cords will be placed within the resident's reach in the resident's room.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36924</p> <p>Based on interview and record review, the facility failed to accurately code significant weight loss on the Minimum Data Set (MDS, an assessment and screening tool), for one of one resident (Resident 176).</p> <p>This failure resulted in an inaccurate assessment of Resident 176's status and had the potential to result in unmet individualized needs and affect the resident's physical and psychosocial well-being.</p> <p>Findings:</p> <p>During a review of Resident 176's Admission Record (AR), the AR indicated Resident 176 was admitted to the facility 11/1/2023 and readmitted on [DATE] with diagnoses that included unspecified dementia (lose the ability to think, remember, learn, make decisions, and solve problems), heart failure (heart doesn't pump blood as well as it should), and generalized muscle weakness (loss in muscle strength).</p> <p>During a review of Resident 176's undated History &amp; Physical (H&amp;P), the H&amp;P indicated Resident 176 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 176's Weights and Vitals Summary, dated 7/11/2024, the Weights and Vitals Summary indicated Resident 176 weighed 193 pounds (lbs., unit of weight) on 11/13/2023 and Resident 109 weighed 161 lbs. on 7/4/2024, indicating a 16.58% significant weight loss (more than 10% weight loss in six months).</p> <p>During a review of Resident 176's quarterly MDS, dated [DATE], the MDS (submitted by the facility) indicated Resident 176 had severe cognitive (ability to understand and process information) impairment. The MDS indicated Resident 176 required supervision or touching assistance with sit to stand, toilet transfers, and when walking 10 feet. The MDS's type of assessment's included admission, quarterly, annual, significant change in status. The MDS, section K, did not indicate Resident 176 had experienced significant weight loss. The MDS, section Z, indicated the MDS was completed 6/25/2024.</p> <p>During a concurrent interview and record review of Resident 176's MDS, dated [DATE], on 07/09/2024, at 3:41 PM, with Registered Dietitian (RD), the MDS did not indicate Resident 176's significant weight loss over the last six months. The RD stated the MDS V Section was not triggered. The RD stated the V section of the MDS represented Care Area Assessments (CAA) for nutritional status and dehydration/fluid maintenance. The RD stated Resident 176's MDS was not accurate, and section K did not indicate Resident 176 had experienced significant weight loss over the last six months.</p> <p>During an interview on 7/10/2024 at 2:33 PM, with the MDSN, the MDSN stated the RD completed Section K of Resident 176's MDS.</p> <p>(continued on next page)</p>		

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F 0641  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During a record review of the facility's Policy & Procedure (P&P), titled, RAI Process, dated 10/4/2016, the P&P indicated its purpose was to provide resident-assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal guidelines and data submission requirements.		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48729</p> <p>Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 57 and Resident 161) had a resident-centered care plan developed and implemented that addressed:</p> <p>a. Resident 57's risk for falls.</p> <p>b. Resident 161's actual fall that occurred on 7/8/2024.</p> <p>These failures had the potential to result in unmet individualized needs for Residents 57 and Resident 161 and the potential to affect the resident's physical well-being. Additionally, there was a potential for Residents 57 and 161 to not receive the necessary care and services to achieve their optimal level of functioning.</p> <p>Findings:</p> <p>a. During a review of Resident 57's Admission Record (AR), the AR indicated Resident 57 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus (disease that occurs when a person's blood sugar is too high), with diabetic neuropathy (nerve damage that can occur as a result of diabetes causing pain) and Parkinson's disease (progressive disease of the nervous system resulting in unintended or uncontrollable movements such as shaking, stiffness, and difficulty with balance and coordination).</p> <p>During a review of Resident 57's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/11/2024, the MDS indicated Resident 57 used a wheelchair. The MDS indicated Resident 57 required substantial/ maximal assistance (helper does more than half the effort) to transfer to and from a bed to a chair (or wheelchair).</p> <p>During a review of Resident 57's History and Physical (H&amp;P) dated 5/15/2024, the H&amp;P indicated Resident 57 had the capacity to understand and make decisions.</p> <p>During an interview on 7/9/2024 at 4:20 PM with Resident 57, Resident 57 stated before the fall [6/25/2024] Resident 57 was getting in and out of bed independently.</p> <p>During an interview on 7/9/2024 at 5:04 PM with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated Resident 57 required reminders to lock the wheelchair and Resident 57 had an increased risk for falls when Resident 57 transferred independently.</p> <p>During an interview on 7/10/2024 at 11:55 AM with the Restorative Nursing Assistant (RNA), the RNA stated Resident 57 was educated on how to transfer from bed to chair and from chair to bed but sometimes Resident 57 went too fast which might cause Resident 57 to forget to lock the wheelchair. The RNA further stated Resident 57 transferred independently but should have supervision when ambulating.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 7/11/2024 at 10:10 AM with Registered Nurse 2 (RN 2), Resident 57's Care Plan (CP) related to risk for falls dated 5/8/2024 was reviewed. The CP indicated interventions including, anticipate and meet the resident's needs, follow facility fall protocol and educate the resident/family/ caregivers about safety reminders and what to do if a fall occurs. RN 2 stated the interventions in Resident 57's CP were vague, and RN 2 did not know what they meant. RN 2 stated Resident 57 required reminders and education on locking Resident 57's wheelchair prior to transferring to and from the wheelchair. RN 2 stated this intervention was not found in the CP and the CP was not individualized to meet Resident 57's needs. RN 2 stated the purpose of the CP was to direct staff to the specific care needed for Resident 57.</p> <p>38108</p> <p>b. During a review of Resident 161's Admission Record (AR) indicated Resident 161 was readmitted to the facility on [DATE] with diagnosis that included psychosis (a mental disorder characterized by a disconnection from reality), lack of coordination, difficulty walking, and muscle weakness.</p> <p>During a review of Resident 161's MDS, dated [DATE], indicated Resident 161 had severe impaired cognition, sometimes understood others, and sometimes made self-understood. The MDS indicated Resident 161 was dependent with eating, toileting and personal hygiene, shower and bathing, and upper and lower body dressing.</p> <p>During an observation in Resident 161's room, on 7/8/2024 at 11:51 AM, Resident 161 was observed on the floor was on Resident 161's back and by the right side of the bed.</p> <p>During a review of Resident 161's eInteract Change in Condition Evaluation - V5.1 (eCOC), dated 7/8/2024, the eCOC indicated Resident 161 experienced an unwitnessed fall/laying on [the] floor mat.</p> <p>During an interview and concurrent record review of Resident 161's paper and electronic chart (medical record) with Licensed Vocational Nurse 6 (LVN 6), on 7/10/2024 at 11:04 AM, LVN 6 stated if a resident (in general) was found on the floor, and the incident was witnessed or not witnessed, it was considered a fall. LVN 6 stated Resident 161 did not have a care-plan regarding the actual fall [that occurred 7/8/2024]. LVN 6 stated care plans were important [because they included] interventions, that assisted (staff) to know what staff were doing (resident care related) and prevent further injuries or accidents [falls].</p> <p>During an interview and concurrent record review of Resident 161's paper and electronic chart, with the Director of Staff Development (DSD), on 7/10/2024 at 2:32 PM, the DSD stated a fall was someone that you saw or found on the ground, regardless of floor mats being present or not. The act of going towards the floor was considered a fall. The DSD stated Resident 161 did not have a care plan for an actual fall. The DSD stated care plans were important to provide proper care to the residents and showed what interventions were to be put in place.</p> <p>During an interview with Registered Nurse 4 (RN 4), on 7/10/2024 at 3:09 PM, RN 4 stated care plans were important because care plans were a part of the nursing process. RN 4 stated, CPs were created when [the facility] identified a problem and the CP indicated interventions needed to attain the goal set for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&amp;P), care plan titled Comprehensive Person-Centered Care Planning, revised 8/24/2023, indicated the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavior, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. The P&amp;P indicated a care plan should address resident specific health and safety concerns to prevent decline or injury and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living as necessary.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36924</p> <p>Based on interview and record review, the facility failed to revise comprehensive Care Plans (CP) for two of two sampled residents (Resident 176 and Resident 36).</p> <p>a. Resident 176's CP was not updated following significant weight loss and to include snacks were increased to three times a day (TID) in Resident 176's nutritional regimen.</p> <p>b. Resident 36's CP was not revised following a fall incident that occurred in the restroom on 6/18/2024.</p> <p>These failures had the potential to result in in unmet individualized needs for Residents 176 and 36 and the potential to affect the resident's physical and psychosocial well-being.</p> <p>Findings:</p> <p>a. During review of Resident 176's Admission Record (AR), the AR indicated Resident 176 was admitted to the facility 11/1/2023 and readmitted on [DATE] with diagnoses that included unspecified dementia (lose the ability to think, remember, learn, make decisions, and solve problems), heart failure (heart doesn't pump blood as well as it should), and generalized muscle weakness (loss in muscle strength).</p> <p>During a review of Resident 176's undated History &amp; Physical (H&amp;P), the H&amp;P indicated Resident 176 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 176's MDS, dated [DATE], the Minimum Data Set (MDS, an assessment and screening tool), indicated Resident 176 had severe cognitive (ability to understand and process information) impairment. The MDS indicated Resident 176 required supervision or touching assistance with sit to stand, toilet transfers, and when walking 10 feet.</p> <p>During an interview with the Registered Dietitian (RD), on 7/9/2024 at 2:54 PM, the RD stated Resident 109 had dementia, heart disease (diseased vessels, structural problems, and blood clots), and heart failure. The RD stated dementia affected hunger and satiety receptors (a feeling of being satisfied/full) were activated by signals arising from gastrointestinal tract (GI) and other organs during meals). The RD stated Resident 109 lost 20 lbs. in one month and the resident's snacks were increased to three times a day (TID) from two times a day (BID) on 5/7/2024.</p> <p>During a concurrent interview and record review of the Order Summary Report, on 7/9/2024, at 4:50 PM, with Quality Assurance Nurse (QAN 2), the Order Summary Report, dated 5/7/2024, indicated snacks TID were approved. QAN 2 stated Resident 109's existing CP that addressed Resident 109s weight loss were not updated/revised to include snacks TID. QAN 2 stated licensed nurses were supposed to update Resident 109's CP upon [receiving] the physician's order. QAN 2 stated it was important to update/revise CP so we can make sure that interventions were followed, residents were getting proper supplements for the weight loss, and did not continue to lose weight.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a record review of Resident 109's Nutritional Risk Assessment, dated 5/6/2024, the Nutritional Risk Assessment indicated snacks BID between meals at 2 PM and at bedtime (HS) were Resident 109's current supplements.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Comprehensive Person-Centered Care Panning, revised 8/24/2023, the P&amp;P indicated the baseline CP must reflect the resident's stated goals and objectives, and include interventions that address his/her needs. The P&amp;P indicated, since the baseline CP is developed before the comprehensive assessment, goals and interventions may change. If the comprehensive assessment and the comprehensive CP identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was not previously identified on the problem specific CPs used for the baseline CP, those changes must be updated on each specific CP used and incorporated, as applicable, into the initial and/or updated baseline CP summaries.</p> <p>50016</p> <p>b. During a review of Resident 36's AR, dated 7/10/2024, the AR indicated the facility admitted Resident 36 on 9/22/2023, with diagnoses including atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the heart] fire rapidly at the same time), congestive heart failure (a condition that develops when the heart does not pump enough blood for the body's needs), history of falling, and muscle weakness.</p> <p>During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36's cognition was severely impaired and required supervision or touching assistance with activities of daily living.</p> <p>During a review of Resident 36's Fall Risk Evaluation, dated 3/28/2024, the Fall Risk Evaluation indicated Resident 36 had balance problems while standing, walking, and had intermittent confusion.</p> <p>During a review of Resident 36's CP, dated 4/8/2024, the CP indicated Resident 36 was at risk for falls related to muscle weakness, history of falling, and lack of coordination. The CP goal indicated Resident 36 falls would be minimized by utilizing interventions and approaches in place through the review date.</p> <p>During a review of Resident 36's Situation Background Assessment Recommendation (SBAR- a verbal or written communication tool that helps provide essential, concise information, usually during crucial situations) Communication form, dated 6/18/2024, the SBAR indicated Resident 36 fell on [DATE] at approximately 12 PM. The SBAR indicated Resident 36 sustained a forehead laceration.</p> <p>During a concurrent interview and record review on 7/9/2024 at 3:10 PM with Registered Nurse (RN) 1, Resident 36's CP dated 4/8/2024, was reviewed. RN 1 stated that the care plan was not revised after Resident 36 had a fall on 6/18/2024. RN 1 stated that the CP for fall should have been revised, to implement additional interventions to avoid the incident from reoccurring.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Park Avenue Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1550 North Park Avenue Pomona, CA 91768	
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 7/10/2024 at 12:32 PM with the Quality Assurance Nurse (QAN) 1, Resident 36's Interdisciplinary Team (IDT-a group of health care professionals with various areas of expertise who work together toward the goals of the resident) progress notes and care plan, were reviewed. QAN 1 stated no new interventions or approaches to prevent further falls were noted on the IDT progress notes dated 6/19/2024, and QAN 1 stated that the care plan was not revised after Resident 36 sustained a fall on 6/18/2024. QAN 1 stated Resident 36's care plan for at risk for fall should have been revised to implement modified or additional interventions that could potentially avoid fall from happening again. QAN 1 stated not revising the care plan and interventions places Resident 36 at increased risk for recurrent fall.</p> <p>During a review of the facility's P&amp;P titled, Comprehensive Person-Centered Care Planning, dated revised on 8/24/2023, the P&amp;P indicated that the comprehensive care plan will be periodically reviewed and revised by IDT after each assessment which means after each MDS assessment as required, except discharge assessments. In addition, the comprehensive care plan will also be reviewed and revised at the following times:</p> <ul style="list-style-type: none"> <li>Onset of new problems.</li> <li>Change of condition.</li> <li>In preparation for discharge.</li> <li>To address changes in behavior and care.</li> <li>Other times as appropriate or necessary.</li> </ul> <p>During a review of the facility's policy &amp; procedure (P&amp;P) titled, Fall Management Program, dated revised on 3/13/2021, indicated that the IDT will initiate, review, and update the Resident's fall risk status and care plan at the following intervals: on admission, quarterly, annually, upon identification of a significant change of condition, post fall and as needed.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31333</p> <p>Based on observation, interview, and record review, the facility failed to follow their own policy and procedure (P&amp;P) to ensure safe medication administration for residents with a Gastrostomy tube (G-tube, a tube that placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) for one of two residents (Resident 510). On 7/9/2024, Licensed Vocational Nurse 3 (LVN 3) administered medications through Resident 510's G-tube, LVN 3 failed to stop and reassess Resident 510, notify the supervisor (in general), or contact the physician (MD) when Resident 510's g-tube became clogged for over 30 minutes.</p> <p>This failure increased the risk of pain or discomfort to Resident 510 and had the potential to cause the displacement of Resident 510's G-tube and/or aspiration (inhaling food, stomach acid, medication, or saliva into the lungs).</p> <p>Findings:</p> <p>During a review of Resident 510's Admission Record (AR), the AR indicated Resident 510 was admitted to the facility on [DATE], with diagnoses that included, encounter for attention to gastrostomy, gastrostomy infection, and ascites (a condition in which fluid collects in spaces within your abdomen).</p> <p>During a review of Resident 510's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 6/30/2024, the MDS indicated Resident 510 had moderate cognitive (ability to understand and process information) impairment and was totally dependent upon facility staff for activities of daily living (ADL, a term used in healthcare that refers to self-care activities).</p> <p>During a medication administration observation on 7/9/2024 from 9:42 AM with LVN 3, LVN 3 was observed preparing the following morning medications scheduled at 9 AM for Resident 510:</p> <ol style="list-style-type: none"> <li>1. Amiodarone (a medication to treat heart rhythm problems) 200 milligrams (mg, unit of measurement), one tablet.</li> <li>2. Eliquis (a medication to help to prevent blood clots from forming) 5 mg, one tablet.</li> <li>3. Levothyroxine (hormone replacement) 100 microgram (mcg, a unit of weight), one tablet.</li> <li>4. Furosemide (water pill) 20 mg., one tablet.</li> <li>5. Vitamin C (vitamin supplement) Liquid 500 mg/5 milliliters (ml, unit of volume), 5 ml.</li> <li>6. Ferrous Sulfate (treat anemia, low number of red blood cells) 220 mg/ 5 ml, 7.5 ml.</li> <li>7. Potassium Chloride (for low potassium levels) Oral Solution USP 10 % 20 MEQ/15 ml, 15 ml with instructions to, Dilute prior to Administration.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 7/9/2024 at 10 AM, with LVN 3, LVN 3 crushed Resident 510's medication tablets separately and placed the crushed medication into individual medication cups. LVN 3 entered Resident 510's room to administer Resident 510's morning medications. Resident 510 was observed lying down on the bed with the head of the bed raised and Resident 510's family member was sitting in a chair at the resident's bedside. LVN 3 stated Resident 510's feeding was turned off. LVN 3 checked the placement of the G-tube and stated there was zero residual (volume of fluid remaining in the stomach) when LVN 3 pulled back on the plunger of the syringe. Resident 510's G-tube was observed filled with a milky substance that stretched the length of the G-tube and was not passing through the G-tube into the resident's stomach. LVN 3 placed the syringe tip into G-tube port opening and stated LVN 3 put 30 ml of water into the syringe. The milky substance inside the syringe was not passing through the G-tube and no water was observed entering the G-tube. LVN 3 tried a gentle push without success. LVN 3 squeezed the G-tube between her fingers along the length of the tube (milking the tube) for over 30 minutes.</p> <p>During an observation on 7/9/2024 at 10:37 AM, LVN 3 was observed applying a lubricating gel and continued milking the G-tube more forcefully, pushing the feeding along the G-tube toward Resident 510's stomach. LVN 3 was not observed stopping to assess the reason for Resident 510's persistent G-tube clog.</p> <p>During an interview on 7/9/2024 at 2:39 PM with LVN 3, LVN 3 stated LVN 3 usually milked the G-tube for as long as it took to clear the G-tube line. LVN 3 acknowledged, milking Resident 510's G-tube, took over 30 minutes today (7/9/2024) to clear Resident 510's G-tube. LVN 3 stated LVN 3 had a hard time yesterday (7/8/2024), with Resident 510's G-tube and it took about 15 minutes of milking Resident 510's G-tube before the clog cleared. LVN 3 stated LVN 3 had not notified her supervisor or Resident 510's physician, [to make them aware], Resident 510's G-tube was persistently clogged yesterday, 7/8/2024, and LVN 3 did not ask her supervisor for help today, 7/9/2024, when the G-tube was persistently clogged for over 30 minutes.</p> <p>During an interview on 7/9/2024 at 3:08 PM with Registered Nurse 3 (RN 3), RN 3 stated Resident 510's G-tube should have been flushed first to remove the last of the feeding when the feeding was first turned off and the only thing that should have been in the tubing was water and maybe a little residual. RN 3 stated it was not normal practice to milk the G-tube for 15 to 30 minutes, RN 3 stated that was too long. RN 3 stated LVN 3 should have asked for help from a colleague, an RN supervisor, or called Resident 510's physician for recommendation when the Resident's G-tube was observed clogged and milking of the G-tube had not worked within a short period of time. RN 3 stated the facility has an outside service that comes into the facility to provide resident wound care that can change residents' G-tube at the facility. RN 3 stated there could be damage at the distal end (the end of the G-tube that is inside of the stomach) of the G-tube that cannot be seen that could negative affect Resident 510.</p> <p>During a review of the facility's P&amp;P titled, Enteral Tube Medication Administration, revised date, 2/2020, indicated, Managing Complications .Clogged tube - clogging can occur from kinking of the tube or from internal blockage .</p> <p>a. Check first to see that the tube is not kinked</p> <p>b. If the clog is still present, gently milk the tube from top to bottom to release any clog that may be in this part of the tube</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. Do NOT force-flush the tube or use a rigid object in an attempt to clear the tube. If the clog is persistent, contact the MD if the above techniques fail.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50016</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 36) received treatment and care in accordance with professional standards of practice, physician order, and policy for Medication Administration. The facility failed to ensure Resident 36 who had known and documented allergy with iodine (a chemical element found in small amounts in sea water, used in medicine, photography, and a dye [substance for changing something's color]), was not administered iodine to treat Resident 36's laceration on forehead.</p> <p>This deficient practice had the potential to place Resident 36 at risk for an allergic reaction (are inappropriate responses of the immune system to a normally harmless substance) and could potentially triggered anaphylactic reaction (a severe, life-threatening allergic reaction that needed to be treated right away.).</p> <p>Findings:</p> <p>During a review of Resident 36's Admission Record (AR), dated 7/10/2024, the AR indicated the facility admitted Resident 36 on 9/22/2023 with diagnoses including atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the heart] fire rapidly at the same time), congestive heart failure (a condition that develops when the heart does not pump enough blood for the body's needs), history of falling, and muscle weakness.</p> <p>During a review of Resident 36's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/28/2024, indicated Resident 36's cognition was severely impaired and required supervision or touching assistance with activities of daily living.</p> <p>During a review of Resident 36's Care Plan, dated 10/2/2023, indicated Resident 36 was allergic to iodine. Resident 36's care plan included interventions to anticipate and meet resident needs, and to inform MD (medical doctor), pharmacy, dietary, and nursing of the allergies of the resident. If any signs or symptoms of allergic reaction occurred such as hives, redness, swelling, difficulty breathing report to MD immediately.</p> <p>During a review of Resident 36's Order Summary Report, dated 7/10/2024, indicated that Resident 36 had an iodine allergy. Resident 36's order summary report also indicated to treat mid forehead every day for laceration with four (4) sutures status post fall for 30 days and cleanse with normal saline, pat dry, apply iodine, and cover with dry dressing with a start date of 6/19/2024.</p> <p>During a concurrent interview and record review on 7/11/2024 at 8:50 AM, with Treatment Nurse (TN) 1, Resident 36's Treatment Administration Record for June 2024 and July 2024, were reviewed. TN 1 stated Resident 36's laceration in forehead was treated with iodine from 6/19/2024 through 7/9/2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 7/11/2024 at 9:02 AM, with TN 1, Resident 36's Order Summary Report, dated 6/19/2024 were reviewed. TN 1 stated Resident 36 order indicated Resident 36 had allergy with iodine but Resident 36 laceration in forehead was being treated with iodine. TN 1 stated she did not question the order to administer iodine to treat Resident 36's laceration in forehead as she assumed Resident 36 allergy with iodine was for food and not for topical (a medication applied to a body surface, including the skin or the inside of the mouth) medication. TN 1 verified that Resident 36's medical record did not specify what type of exposure to iodine would cause allergic reaction and what reaction or symptoms Resident 36 would develop from the exposure to iodine. TN 1 stated that she should have clarified the order for iodine and Resident 36's allergy for iodine with the physician for resident's safety. TN 1 stated Resident 36 never developed any reaction from the iodine treatment and never noted or observed anything unusual with the application of the iodine.</p> <p>During an interview on 7/11/2024 at 10:04 AM, Quality Assurance Nurse (QAN) 1 stated nurses administering medication should check first if the resident has allergy with the medication. QAN 1 stated if a resident has known allergy with the ordered medication, the nurse should check with physician first and clarify any conflicting order that could potentially harm the resident even if it will cause a delay in treatment, because the resident's safety always comes first.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Medication Administration, revised 1/1/2012, indicated that administration of medication orders will be reviewed for allergies, food/drug interaction.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure a nasal cannula (NC, a device-lightweight flexible plastic tubing used to deliver supplemental oxygen, tubing ending is placed in the nostrils and is fitted over the patient's ears) was labeled with a date and a cautionary sign was posted on the resident's door to indicate oxygen was in use and no smoking in the room, for one of three sampled residents (Resident 61) receiving oxygen therapy.</p> <p>This deficient practice placed Resident 61 at an increased risk of acquiring an infection and the potential for a decline in physical well-being.</p> <p>Findings:</p> <p>During a review of Resident 61's Admission Record indicated Resident 61 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and asthma (narrowing of the lung that makes it hard to breathe).</p> <p>During a review of Resident 61's Minimum Data Set (MDS, an assessment and screening tool), dated 4/4/2024, the MDS indicated Resident 61 had severe impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 61 required set up or clean up assistance (helper set-up and cleans up) with toilet hygiene, showers, and lower body dressing.</p> <p>During a review of Resident 61's Order Summary Report (OSR), dated active orders 7/9/2024, the OSR included a physician's order dated 7/6/2024, the order indicated oxygen at two liters per minute (L/min) via nasal cannula ([NC] a device consisting of a lightweight tubing used to deliver supplemental oxygen) as needed to keep Resident 61's oxygen saturation (amount of oxygen carried in the blood) above 92%.</p> <p>During an observation on 7/8/2024 at 12:39 PM, Resident 61 was asleep and lying in bed. Resident 61 had a NC and the NC's tubing was connected to an oxygen machine. The NC was unlabeled, and no sign was posted on Resident 61's door to indicate oxygen was in use in Resident 61's room or to indicate smoking was prohibited.</p> <p>During a concurrent observation and interview on 7/8/2024 at 12:40 PM, with Director of Staff Development 1 (DSD 1), Resident 61 was awake and lying in bed, DSD 1 stated, the oxygen tubing was not labeled, there was no sign posted on Resident 61's door to indicate oxygen was in use or to indicate smoking was prohibited in Resident 61's room. DSD 1 stated there should be a smoking sign to remind visitors and residents not to smoke inside the room because oxygen could ignite and cause a fire.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and concurrent interview with the Director of Staff Development (DSD) on 7/8/2024 at 12:40 PM, the DSD stated NC tubing should be labeled with the resident's name and date for infection control purposes and to ensure the NC tubing was functioning properly. The DSD stated, smoking signs should be posted at the entrance of room doors of residents receiving oxygen therapy for fire safety because oxygen was combustible, and smoking was not allowed [in areas where oxygen was in use].</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Oxygen Therapy, revised 11/2017, the P&amp;P indicated to ensure the safe storage and administration of oxygen in the facility. The P&amp;P indicated, No smoking signs will be prominently displayed wherever oxygen is being stored or administered. Oxygen tubing, mask, and nasal cannulas (NC) will be changed no more that every seven days and as needed. The supplies will be dated each time they are changed.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31333</p> <p>Based on observation, interview, and record review the facility failed to ensure safe medication administration and accurate accountability of all controlled medications (medications with a high potential for abuse) as indicated in the facility's policy and procedures (P&amp;P) by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure one of two sampled resident's (Resident 510) medications for potassium chloride (a medicine used to prevent or treat low potassium levels in the body, side effects include stomach bloating, severe vomiting, severe stomach pain, stomach irritation, or chest pain), administered through a Gastrostomy tube (G-tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), was administered with sufficient fluid in accordance with the manufacturer's specification.</li> <li>2. Ensure the Controlled Drug Record form (CDR/Narcotic run sheet- accountability record of medications that are considered to have a strong potential for abuse) coincided with the Medication Administration Record (MAR, a log initialed and/or signed by the nurse with the date and time each time a medication is administered to a resident) for an administered dose of a controlled medication (Tramadol 50 milligrams [mg. unit of measurement], used to treat and manage pain) on [DATE] at 6 AM for Resident 146.</li> <li>3. Ensure the prescription label on the MAR and the current physician orders matched for Resident 78's controlled medication, oxycodone.</li> <li>4. Ensure an accurate accountability of the inventory of all controlled drugs was maintained at all times throughout the facility: from delivery to the facility, to administration of the drug, to final disposal/destruction of the drug.</li> <li>5. Ensure Licensed Vocational Nurse 9 (LVN 9) administered the correct medication to treat one of two sampled resident's (Resident 112) moderate pain (pain level 5 to 7, a pain scale is from 0 to 10, 0 means no pain and 10 means the worst possible pain felt). On [DATE], LVN 9 administered Acetaminophen 325 milligrams (mg. unit of measurement) when Acetaminophen was ordered to treat mild pain (pain level 1 to 4).</li> <li>6. Ensure LVN 5 administered the correct medication, to treat one of two sampled resident's (Resident 112) mild pain. On [DATE], LVN 5 administered Norco (pain medication used to treat moderate [pain level 5 to 7] to severe [pain level 8 to 10] pain levels) ,d+[DATE] mg., to treat Resident 112's mild pain level of 4.</li> </ol> <p>These deficient practices created the potential for unsafe medication administration of necessary medications to residents, the potential for inability to readily identify loss and drug diversion (illegal distribution of abuse of prescription drugs or their use for unintended purposes) of controlled medications and resulted in an increased the risk for inaccurate reconciliation of controlled medications throughout the facility.</p> <p>Findings:  (continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. During a review of Resident 510's Admission Record (AR), the AR indicated Resident 510 was admitted to the facility on [DATE], with diagnoses that included, encounter for attention to gastrostomy, gastrostomy infection, and ascites (a condition in which fluid collects in spaces within your abdomen).</p> <p>During a review of Resident 510's Care Plan (CP) for Congestive Heart Failure CHF, date initiated [DATE], the CP listed medications that included, Furosemide (Lasix, a diuretic, used to treat fluid retention and swelling) 20 mg via G-tube daily and Potassium Chloride 20 mEq/ 15 ml via G-tube every day. The CP's interventions indicated, Give cardiac medications as ordered, monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of hypokalemia (low levels of potassium in the blood) in residents receiving diuretic therapy: fatigue, muscle weakness, diminished appetite, nausea and vomiting and dysrhythmias (irregular heartbeat) .</p> <p>During a review of Resident 510's telephone physician order, for Potassium Chloride Liquid 10 percent (%) 20 milliequivalents (mEq, unit of measure) per 15 milliliters (ml, unit of volume), order dated [DATE], the order's instructions indicated, give 15 ml (20 mEq) via G-tube one time a day for supplement.</p> <p>During a review of Resident 510's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated [DATE], the MDS indicated Resident 510 had moderate cognitive (ability to understand and process information) impairment and was totally dependent upon facility staff for activities of daily living (ADL, a term used in healthcare that refers to self-care activities).</p> <p>During a review of Resident 510's MARs for the months of ,d+[DATE] and ,d+[DATE], the MARs indicated Resident 510 was administered Potassium Chloride Liquid 20 MEQ/15ML (10%), 15 ml via G-Tube one time a day for Supplement daily from [DATE] to [DATE].</p> <p>During a concurrent medication pass observation and interview on [DATE] from 9:42 AM to 10:56 AM, with a licensed vocational nurse (LVN) 3, LVN 3 was observed preparing the following morning medications scheduled at 9 AM for Resident 510:</p> <ol style="list-style-type: none"> <li>1. Amiodarone (a medication to treat heart rhythm problems) 200 mg, one tablet</li> <li>2. Eliquis (a medication to help to prevent blood clots from forming) 5 mg, one tablet</li> <li>3. Levothyroxine (hormone replacement) 100 microgram (mcg, a unit of weight), one tablet</li> <li>4. Furosemide (water pill) 20 mg., one tablet</li> <li>5. Vitamin C (vitamin supplement) Liquid 500 mg/5 ml, 5 ml</li> <li>6. Ferrous Sulfate (treat anemia, low number of red blood cells) 220 mg/ 5 ml, 7.5 ml</li> <li>7. Potassium Chloride (for low potassium levels) Oral Solution USP 10 % 20 MEQ/15 ml, 15 ml with instructions to, Dilute prior to Administration</li> </ol> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Park Avenue Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1550 North Park Avenue Pomona, CA 91768	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on [DATE] at 10 AM, with LVN 3, LVN 3 crushed Resident 510's tablets separately and placed the crushed medication into individual medication cups. LVN 3 entered Resident 510's room to administer Resident 510's morning medications.</p> <p>During an interview on [DATE] at 10:01 AM, LVN 3 stated Resident 510's feeding was turned off. LVN 3 stated Resident 510's G-tube was observed filled with a milky substance that stretched the length of the G-tube and was not passing through the G-tube into the resident's stomach. LVN 3 squeezed the G-tube between her fingers and along the length of the tube (milking the tube) for over 30 minutes to open the clogged G-tube.</p> <p>During an interview on [DATE] at 10:37 AM, once the G-tube clog was cleared, LVN 3 stated LVN 3 would administer Resident 510's medications directly through the end of the G-tube. LVN 3 performed an initial 30 ml water flush and stated LVN 3 added and mixed 10 ml of water with each of the crushed medications, administered the medications one at a time, followed by 10 ml of water flush between each medication. LVN 3 raised the undiluted 15 ml of Potassium Chloride preparing to pour the medication into the syringe to administer to Resident 510. LVN 3 was stopped and asked if LVN 3 needed to do anything with Resident 510's Potassium Chloride Oral Solution prior to administering through the G-tube. LVN 3 stated, I usually administer the potassium and follow it with a 5 ml to 10 ml of water flush. LVN 3 stated there was no instructions to administer the potassium any other way and there was no instruction on diluting potassium prior to administration.</p> <p>During a concurrent interview and record review on [DATE] at 10:55 AM, with LVN 3, LVN 3 reviewed Resident 510's prescription order for potassium and stated Resident 510's order indicated to administer 15 ml of potassium once time a day as a supplement.</p> <p>During an interview on [DATE] at 10:56 AM, with LVN 3, LVN 3 reviewed the manufacture's bottle of Potassium Chloride Oral Solution that was labeled for Resident 510, LVN 3 stated the manufacturer's label indicated Dilute prior to administration, but did not indicate how much water to use to dilute the potassium. LVN 3 stated if LVN 3 knew the medication (potassium ) needed to be diluted, then LVN 3 would have called the pharmacy and asked.</p> <p>During a telephone interview on [DATE] at 11:13 AM, with LVN 3, LVN 3 called the facility's dispensing pharmacy and spoke with a pharmacist (Pharm 1), Pharm 1 stated Potassium Chloride Oral Solution was required to be diluted with at least four ounces ([oz] - a unit of measure for volume) of water to prevent stomach irritation.</p> <p>During an interview on [DATE] at 2:41 PM, with the Assistant Director of Nursing (ADON), the ADON stated the ADON was not aware that Potassium Chloride Oral Solution required dilution prior to administration.</p> <p>During an interview on [DATE] at 10:38 AM, with Registered Nurse 3 (RN 3), RN 3 called the facility's dispensing pharmacy and spoke with a different pharmacist (Pharm 2). Pharm 2 stated, Potassium Chloride for Oral Solution must be diluted with at least four oz of water regardless the route of administration, oral or via G-tube, to prevent stomach irritation, and Gastrointestinal (GI, symptoms such as heartburn, indigestion/dyspepsia, bloating and constipation) upset.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P titled, General Guidelines for Administering Medication Via Enteral Tube, revised ,d+[DATE], the P&amp;P indicated, Medications that are GI irritants (such as potassium chloride solution) are diluted as recommended for oral administration, since there is a high potential for gastric irritation when medications are administered directly into the stomach through enteral tubes. The consultant pharmacist and/ or dispensing pharmacy is contacted with questions and the physician is contacted if new orders are necessary.</p> <p>During a review of the facility's resource provided, undated, titled, Potassium Chloride Oral - Drug Facts and Comparisons, received on [DATE], the manufacturer labeling for potassium chloride for oral solution indicated, Dilute with at least 120 ml of cold water. If GI irritation occurs, increase dilution.</p> <p>2. During a review of Resident 146's Admission Record indicated the facility admitted the resident on [DATE] with diagnoses that included fracture of left femur (thigh bone), dislocation of foot, Traumatic Brain Injury (TBI, occurs when a sudden trauma causes damage to the brain), and muscle weakness.</p> <p>During a review of Resident 146's MDS, dated [DATE], indicated Resident 146 had severe cognitive impairment. The MDS indicated Resident 146 was substantially or totally dependent upon facility staff for activities of daily living</p> <p>During a review of Resident 146's Order Summary Report, included a physician's order, dated [DATE], for tramadol 50 mg. with instructions to give one tablet by mouth every six (6) hours for pain management and to hold the medication if Resident 146 was drowsy or sleepy or if the respiration rate was less than 12 breaths per minute.</p> <p>During a review of Resident 146's MAR for the month of ,d+[DATE], the MAR indicated the Resident 146 was last administered a dose of tramadol 50 mg. on [DATE], for Resident 146's 12 AM scheduled administration time.</p> <p>During a concurrent interview and record review on [DATE] at 11:36 AM., with LVN 4 and the ADON, Resident 146's Controlled Drug Record form and MAR were reviewed. LVN 4 verified that one dose of tramadol 50 mg was documented on the CDR form on [DATE] at 6:30 AM and there was no corresponding documentation or licensed nurse's initials on the MAR to indicate that Resident 146 was administered the scheduled 6 AM dose on [DATE]. The ADON stated Resident 146's MAR was not updated to indicate Resident 146 was administered the scheduled 6 AM dose on [DATE]. The ADON stated the expectation was for the licensed nurse that prepared the medication for the resident (in general) to document immediately after the administration on the resident's MAR. The ADON stated that failing to document on the resident's MAR immediately after the administration of a controlled medication was not in accordance with the facility's policy and created confusion for the next nurse to try and verify whether Resident 146 was administered the pain medication. The ADON stated the next nurse would need to assess Resident 146 for pain or discomfort.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P titled, Preparation and General Guidelines-Controlled Substances, revised ,d+[DATE], the P&amp;P indicated, Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following on the accountability record and the medication administration record (MAR) .Date and time of administration (MAR, Accountability Record) .Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record)</p> <p>3. During a review of Resident 78's Admission Record indicated the facility initially admitted Resident 78 on [DATE] and readmitted the resident on [DATE], with diagnoses that included chronic (long standing) pain syndrome and muscle spasm.</p> <p>During a review of Resident 78's MDS, dated [DATE], indicated Resident 78 had moderate cognitive impairment. The MDS indicated Resident 146 was totally dependent upon facility staff for ADLs.</p> <p>During a review of Resident 78's Order Summary Report, active orders dated [DATE], included a physician's order for oxycodone 10 mg, dated [DATE], with instructions to give one tablet by mouth every six (6) hours as needed (PRN) for moderate pain, severe to excruciating pain. The order indicated, if the medication was not effective to notify MD (physician) and to hold the medication if Resident 78 was drowsy or sleepy or if the respiration rate was less than 12 breaths/ minute, order date.</p> <p>During a review of Resident 78's MAR for the months of ,d+[DATE], ,d+[DATE], and ,d+[DATE], the MARs indicated Resident 78 was last administered a dose of oxycodone 10 mg, on [DATE] at 10:18 AM for a pain level of seven.</p> <p>During a concurrent interview and record review on [DATE] at 11:57 AM with the ADON in Nursing Station 2, Medication Cart 1, Resident 78's CDR for oxycodone, prescription labels, and actual medication inside of the two medication blister packs (blister pack, a card that packages doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles, or blisters) were reviewed. The blister of oxycodone for Resident 78 was labeled with the following instructions:</p> <p>a. Blister pack 1 labeled for Resident 78 indicated, oxycodone 10 mg, with instructions to take one tablet by mouth every six hours as needed for severe pain (8 - 9), order date [DATE]. There was no parameter to instruct the licensed nurse to check Resident 78's respiration rate prior to administering the medication.</p> <p>b. Bister pack 2 labeled for Resident 78 indicated, oxycodone IR (immediate release) 10 mg, with instructions to take one tablet by mouth every six hours as needed for moderate to excruciating pain. There was no pain scale or parameter to instruct the licensed nurse to check Resident 78's respiration rate prior to administering the medication.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The ADON stated the facility was not using the CDR forms provided by the dispensing pharmacy. The ADON stated the dispensing pharmacy delivered the controlled medications to the facility with individual CDR forms for each medication and the facility's licensed nurses would handwrite the information from the pharmacy provided CDR forms onto a form titled Individual Narcotic Record located inside of a bound book with numbered pages. The ADON stated each time the bound controlled book was changed a new CDR form for each resident prescribed controlled medications would have to be rewritten. The ADON stated Resident 78's CDR forms were changed and entered into a new controlled book and the new controlled book did not include the last date Resident 78's oxycodone was pulled from the blister packs or administration to Resident 78. The ADON stated we [the facility] have lost the traceability of the controlled medications when we change from the pharmacy provided CDR forms to the facility's controlled medication books and do not accurately record when the controlled medications were originally delivered to the facility or keep an accurate perpetual (occurring continually) record for the removal and administration of each dose of controlled medications.</p> <p>During an interview and record review on [DATE] at 12:13 PM with the ADON, the ADON reviewed Resident 78's physician orders and stated Resident 78's order for oxycodone 10 mg with instructions to take one tablet by mouth every six hours as needed for severe pain (8 - 9), order date [DATE] was discontinued on [DATE] and should have been removed from Nursing Station 2, Medication Cart 1. The ADON stated there was a potential for controlled drug loss or diversion.</p> <p>During a review of the facility's P&amp;P titled, Controlled Substances, revised ,d+[DATE], indicated, Accurate accountability of the inventory of all controlled drugs is maintained at all times.</p> <p>4. During an interview and controlled medication reconciliation review on [DATE] at 12:24 PM with the Director of Nursing (DON) inside of the DON's office. The DON stated the process for the disposal of discontinued controlled medications was:</p> <ol style="list-style-type: none"> <li>1. The facility's licensed nurses remove the discontinued or expired blister pack of controlled medications from the medication carts and give them to the DON.</li> <li>2. The DON would then count and dispose/destroy the discontinued/ expired controlled medications monthly with the facility's Consultant Pharmacist and document the disposal on a form titled, Controlled Substance Disposition Log, and record the date of disposal and the quantity being disposed of.</li> </ol> <p>The DON stated when the controlled medications were ready for disposal the CDR forms may be in storage or inside of different controlled books that the facility created and not readily available to enable an accurate reconciliation of all controlled medications. The DON stated there was a potential to lose track of controlled medications when the original CDR was not used to compare and reconcile the controlled medication. The DON stated reconciliation of controlled medications could become difficult to track, trace, and ensure the accuracy and accountability of all controlled medications.</p> <p>During a review of the facility's P&amp;P titled, Controlled Substance Storage, revised ,d+[DATE], indicated, A controlled substance accountability record is prepared by the pharmacy/facility for all Schedule II, III, IV, and V medications (see Form 12: Individual Resident's Controlled Substance Record, although some states require a bound book with numbered pages), including those in the emergency supply. The following information is completed on the accountability form upon dispensing receipt of a controlled substance or use of a controlled substance from the emergency supply:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>i. Name of resident</p> <p>ii. Prescription number</p> <p>iii. Name, strength, and dosage form of medication</p> <p>iv. Date received</p> <p>v. quantity received</p> <p>vi. Name of person receiving medication supply .</p> <p>Controlled substance inventory is regularly reconciled to the Medication Administration Record (MAR) and Form 12: Individual Resident's Controlled Substance Record.</p> <p>Current controlled substance accountability records are kept in the MAR, designated book. Complete accountability records are submitted to the director of nursing and kept on file for 3 years at the facility.</p> <p>36924</p> <p>5 - 6. During a review of Resident 112's Admission Record (AR), the AR indicated Resident 112 was admitted to the facility on [DATE] with diagnoses that included epilepsy (a disorder in which nerve cell activity in the brain is disturbed and causes seizures), cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), unspecified dementia (lose ability to think, remember, learn, make decisions, and solve problems), heart failure (heart doesn't pump blood as well as it should), and generalized muscle weakness (loss in muscle strength).</p> <p>During a review of Resident 112's History &amp; Physical (H&amp;P), dated [DATE], the H&amp;P indicated Resident 112 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 112's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated [DATE], the MDS indicated Resident 112 had severe cognitive (ability to understand and process information) impairment. The MDS indicated Resident 112 required substantial/maximal assistance with showers/bathing self, and supervision or touching assistance with toileting and when walked 50 feet with two turns.</p> <p>During a review of Resident 112's Order Summary Report (OSR), active orders dated [DATE], the OSR included a physician's order dated [DATE] that indicated Acetaminophen (medication to treat mild pain) tablet 325 mg., give two tablets by mouth every six hours as needed for mild pain levels 1 to 4 and a physician's order dated [DATE] for Norco Oral tablet ,d+[DATE] mg, give one tablet, by mouth, every four hours as needed for moderate pain and severe-excruciating pain.</p> <p>During a review of Resident 112's General Acute Care Hospital 1's (GACH 1) Radiology Results Report, dated [DATE], the report indicated Resident 112 had an oblique (neither parallel nor at a right angle) fracture (a break or crack in a bone) of the third metacarpal (five short, tubular bones in the hand).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review of the Medication Administration Record (MAR), dated June and [DATE], on [DATE], at 3:15 PM, with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated Resident 112 was always able to verbalize and express Resident 112's pain level. LVN 5 stated LVN 5 documented a pain level of 4 on the MAR and administered Norco ,d+[DATE] mg. on [DATE] to Resident 112. LVN 5 stated Norco ,d+[DATE] mg., was not indicated for Resident 112's pain level of 4 (mild pain) because Norco was indicated for excruciating pain.</p> <p>During a concurrent interview and record review of Resident 112's Order Summary Report (OSR), active orders dated [DATE] and Resident 112's MAR dated June and [DATE], on [DATE] at 3:16 PM, with LVN 5, the OSR included a physician's order, dated [DATE], that indicated Norco ,d+[DATE] mg. as needed for moderate pain level 5 to 7 and severe-excruciating pain level 8 to 10. LVN 5 stated if Resident 112 was not in moderate or excruciating pain Resident 112 did not need administration of Norco ,d+[DATE] mg. LVN 5 stated [administration] of Norco ,d+[DATE] mg. could make residents extra sleepy. Based on review of the MAR, LVN 5 stated LVN 5 administered Norco ,d+[DATE] mg. to Resident 112 on [DATE] for a pain level of 4 and Norco was not the correct medication ordered for a pain level of 4.</p> <p>During a concurrent interview and record review of Resident 112's MAR dated [DATE], on [DATE], at 3:42 PM, with LVN 9, LVN 9 stated the MAR indicated Resident 112 received Acetaminophen 325mg., two tablets for a pain level of 7 on [DATE] administered by LVN 9. LVN 9 stated Resident 9 was screaming and screaming did not indicate mild pain. LVN 9 stated at that time LVN 9 provided a quick response by administering Acetaminophen 325 mg. to Resident 112 and LVN 9 was not aware Norco ,d+[DATE] mg. was ordered to treat Resident 112's moderate pain. LVN 9 stated medication rights included the right route, right frequency, right diagnosis, and the right time. LVN 9 stated Acetaminophen 325 mg., two tablets were not the right medication administered to treat Resident 112's pain level of 7. LVN 9 stated it was important to administer the right medication for the right indication, and administer medications as ordered by the physician.</p> <p>During a concurrent interview and record review of the MAR, dated June and [DATE], on [DATE] at 4:50 PM, with the Director of Nursing (DON). The DON stated the MAR indicated Acetaminophen 325mg, two tablets was administered for a pain level of 7 on [DATE] and Norco ,d+[DATE] mg. was administered for a pain level of 4 on [DATE]. The DON stated the five rights of medication administration included the right time, right medication, right name, right route, and the right dose. The DON stated the right medication was not administered for Resident 112's pain level. The DON stated it was important to administer the right medication for the right indication to help the residents (in general). The DON stated, residents could be overmedicated, or undermedicated and residents could remain in pain.</p> <p>During a record review of the facility's P&amp;P, titled, Medication-Administration, dated [DATE], the P&amp;P indicated its purpose was to ensure the accurate administration of medications for residents in the facility: Nursing staff kept in mind the seven rights of medication when administering medications. The seven rights of medication included: i. The right medication, ii. The right amount, iii. The right resident, iv. The right time, v. The right route, vi. Resident has the right to know what the medication does, and vii. Resident has the right to refuse the medication (unless court ordered).</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31333</p> <p>Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 84) remained free of unnecessary psychotropic medication (drug prescribed to affect the mind, emotions, or behavior) use when Resident 84 received quetiapine (Brand Name [Seroquel], antipsychotic, a type of psychotropic medication indicated for psychosis [a collection of symptoms that affect the mind, where there has been some loss of contact with reality]) and trazodone (an antidepressant) for inadequate indications. The facility failed to develop and implement person centered non-pharmacological behavioral interventions ([NPI] any intervention intended to improve the health or the well-being of individuals that do not involve the use of medication) in Resident 84's plan of care.</p> <p>This deficient practice had the potential to result in psychotropic medication adverse effects (unwanted, uncomfortable, or dangerous effects that a resident may have due to an administered medication) such as sedation, confusion, changes in mental state, and falls.</p> <p>Findings:</p> <p>During a review of Resident 84's Admission Record (AR), the AR indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included dementia (a group of conditions, decline in mental ability, that interfere with daily activities), Alzheimer's disease (a brain disorder that gets worse over time), depression, muscle weakness, and difficulty in walking.</p> <p>During a review of Resident 84's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 6/4/2024, indicated the resident was severely cognitively impaired and required setup for eating and oral hygiene, supervision with touch assistance for toileting, and moderate to maximum physical assistance for showering, dressing, and personal hygiene.</p> <p>During a review of Resident 84's physician orders, between 4/25/2024 through 7/11/2024, indicated Resident 84 orders included but not limited to the following medications:</p> <p>a. quetiapine 50 milligrams (mg, a unit of measurement) 1 tablet by mouth once a day in the evening for depression, order date 4/25/2024, discontinued on 5/4/2024, and increased to;</p> <p>b. quetiapine 75 mg once a day by mouth in the afternoon for psychosis m/b (manifested by) scratching and kicking others, order date 5/5/2024, discontinued on 5/15/2024, and increased to;</p> <p>c. quetiapine 75 mg twice a day (total daily dose of 150 mg) for psychosis m/b scratching and kicking others, order date of 5/15/2024</p> <p>d. sertraline (antidepressant) 50 mg one time a day for depression manifested by verbalizing depression, order date 5/15/2024,</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>e. trazodone 75 mg by mouth nightly at bedtime for depression m/b inability to sleep, order date 5/17/2024, order was discontinued on 6/5/2024.</p> <p>f. trazodone 50 mg by mouth nightly at bedtime for depression m/b inability to sleep, order date 5/30/2024 was added to the previous order for trazodone 75 mg (for a total daily dose of 125 mg of trazodone) between 5/30/2024 through 6/4/2024.</p> <p>During a review of Resident 84's Care Plans indicated the following:</p> <ol style="list-style-type: none"> <li>1. The resident had a behavior problem of stealing roommates' belongings and hoarding linens, dishes, water pitchers, and utensils, date initiated 5/16/2024. Interventions indicated, Administer medications as ordered. Monitor/ document for side effects and effectiveness .Increase Seroquel (quetiapine) 75 mg BID (twice a day). Resident 84's behavior of stealing roommates belongings care plan did not include resident specific NPI to be used or attempted for the resident.</li> <li>2. The resident uses psychotropic medications quetiapine r/t (related to) psychosis m/b scratching and kicking others, date initiated 6/17/2024. Interventions indicated, Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift .Review behaviors/interventions and alternative therapies attempted and their effectiveness as per facility policy. Resident 84's psychotropic care plan for quetiapine did not include resident specific NPIs to be used or attempted for the resident.</li> </ol> <p>During a concurrent interview and record review on 7/11/2024 at 2:39 PM with Licensed Vocational Nurses (LVN 5 and LVN 11), Resident 84's Medication Administration Records (MARs) for the months of 5/2024, 6/2024, and 7/2024 were reviewed, the MARs indicated to Monitor target behaviors for the use of (Seroquel) D/T (Psychosis) (scratching and kicking others) Indicate the number of behavior occurrences followed by the NPI # provided . LVN 5 stated the number zero (0) indicated no behaviors were exhibited by Resident 84 and the letters NA meant not applicable and that Resident 84 did not exhibit the behavior of scratching or kicking others. LVN 5 and LVN 11 reviewed Resident 84's MARs for the behavior of scratching and kicking others between 5/17/2024 through 7/10/2024. LVN 5 stated there was zero documented behaviors to indicate Resident 84 scratched or kicked others between 5/17/2024 through 7/10/2024.</p> <p>During an interview on 7/11/2024 at 2:41 PM with LVN 5, LVN 5 stated, Resident 84 had not exhibited any behavior of scratching or kicking that LVN 5 was aware of. LVN 5 stated that LVN 5 had worked with Resident 84 since Resident 84's admission to the facility on [DATE]. LVN 5 stated Resident 84 was usually quiet, reserved to herself, and happy when family visited. LVN 5 stated Resident 84 had dementia and [staff] needed to introduce themselves each time to Resident 84. LVN 5 stated LVN 5 had not documented on the MAR or in the nursing progress notes what NPIs were done for Resident 84 or if they were effective or not.</p> <p>During an interview on 7/11/2024 at 2:42 PM with LVN 11, in the presence of LVN 5, LVN 11 stated, must have patience with Resident 84, must introduce yourself to the resident and explain why you [staff] are there. LVN 11 stated Resident 84 was cooperative during medication administration or when the staff checked Resident 84's blood pressure. LVN 11 stated LVN 11 was not aware that LVN 11 should document NPIs for Resident 84 on the MAR to indicate what non-medication care was provided to Resident 84 and if the interventions were effective or not.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 7/11/2024 at 3:34 PM with the Director of Nursing (DON), Resident 84's psychiatric note dated 5/16/2024, timed at 1:10 PM, was reviewed, the note indicated, This provider called in to see patient who returned from hospital with delusions, going into other patients rooms and taking their belongings, hoarding items, she is on Seroquel for psychosis, Sertraline for depression, trazodone for depression and poor sleep, will increase Seroquel to help manage her psychotic behavior and will add Ativan (lorazepam, a sedative, used to relieve anxiety, a feeling of fear, dread, and uneasiness) PRN (as needed) for anxiety and agitation.</p> <p>During a concurrent interview and review of Resident 84's clinical records on 7/11/2024 at 3:50 PM with the DON, Resident 84's ARs and MARs between 4/2024 through 7/2024 were reviewed. The DON stated Resident 84 did not have documented behaviors of scratching and kicking others between 5/16/2024 through today, 7/11/2024. The DON stated Resident 84 was not admitted with a diagnosis of psychosis, the diagnosis was added by the physician after admission on 5/2024. The DON stated there was no documentation during the month of 4/2024 that indicated Resident 84's targeted behavior for the use of quetiapine was being monitored and there was no documentation of NPI's being done prior to starting or increasing the dose of quetiapine. The DON stated the facility should have provided NPIs prior to initiating psychotropic medications and while the resident was on psychotropic medications. The DON stated that the DON was aware of the FDA Boxed Warning for quetiapine and that there was an increased risk of death in residents with dementia related psychosis.</p> <p>During a review of the facility's undated Food and Drug Administration (FDA) Black Boxed Warning (the highest safety-related warning that medications can have assigned by the Food and Drug Administration) Details, for Quetiapine, the warning indicated elderly patients with dementia - related psychosis treated with antipsychotic medications were at an increased risk of death. Quetiapine was not approved for the treatment of patients with dementia-related psychosis.</p> <p>During an interview on 7/11/2024 at 5:07 PM with Resident 84's Psychiatrist (Physician 1), in the presence of the DON, Physician 1 stated Resident 84 had a diagnosis of dementia. Physician 1 stated the facility should have tried NPIs to avoid other more restrictive measures for Resident 84. Physician 1 stated Resident 84 was started on quetiapine for psychosis and trazodone for depression. Physician 1 stated before deciding to increase Resident 84's psychotropic medications, Physician 1 reviewed the resident's (in general) monitoring sheets to evaluate the specific behaviors exhibited. Physician 1 was informed there was zero targeted behaviors of Resident 84 scratching or kicking others documented on Resident 84's MARs since being started on quetiapine in 4/2024 through 7/11/2024. Physician 1 was asked for the clinical rationale for increasing Resident 84's quetiapine twice within 20 days and increasing trazodone at or about the same time quetiapine was increased. Physician 1 stated Physician 1 typically waited 30 days before adjusting a resident's psychotropic medication and depending on the resident's response to the medication, Physician 1 usually introduced one medication at a time to see how the resident responded before adding another medication. Physician 1 stated Physician 1 would review Resident 84's medical records and provide any additional information Physician 1 may have related to the clinical rationale for increasing Resident 84's quetiapine and trazodone.</p> <p>During a review of Resident 84's Medication Administration Records (MARs) for the months of 5/2024, 6/2024, and 7/2024 indicated the following:</p> <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 84 was administered both doses of trazodone 50 mg and 75 mg together (for a total nightly dose of 125 mg of Trazodone) nightly for depression m/b inability to sleep at 2100 (9:00 PM) on 5/30/2024, 5/31/2024, 6/1/2024, 6/3/2024, and 6/4/2024 before trazodone 75 mg nightly dose was discontinued on 6/5/2024 for Resident 84.</p> <p>Resident 84's monitoring hours of sleep during evening hours and night shift between:</p> <p>5/19/2024 through 5/31/2024 indicated Resident 84 slept seven to 10 hours a day.</p> <p>6/1/2024 through 6/13/2024 indicated Resident 84 slept eight to 12 hours a day.</p> <p>During a telephone interview on 7/11/2024 at 5:25 PM with Resident 84's Responsible Party 1 (RP 1), RP 1 stated, RP 1 visited Resident 84 on 7/7/2024 and Resident 84 was okay for about 15 minutes and then slept during the rest of the visit. RP 1 stated, RP 2 visited Resident 84 on 7/10/2024 and Resident 84 was sleeping during the visit. RP 1 stated during visits with Resident 84, the resident was less aware, and RP 1 believed the medications were too much.</p> <p>As of 7/19/2024 Physician 1 or the facility have not provided any additional information on Resident 84 psychotropic medications.</p> <p>During a review of the facility's P&amp;P titled, Behavior/Psychoactive Drug Management - Nursing Manual General, revised 11/2018, indicated, The Licensed Nurse will document the interventions taken and recommendations in the resident's Care Plan .Provision for Psychoactive Medication Use .Preventable causes of behavior have been ruled out .The Care Plan reflects the non-drug interventions prior to drug treatment, use of psychoactive medication(s), adverse reactions to psychoactive medication(s), and any reduction program in place .Occurrences of behaviors for which psychoactive medications are in use will be entered with hash marks (#) on the medication administration record every shift .Any order for psychoactive medications must include .diagnosis for use; and specific behavior manifested.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Behavior/Psychoactive Medication Management - Nursing and Interdisciplinary Team, revised 1/2024, indicated, If the resident exhibits mood or behavior problems upon admission, assessments will be conducted to address the resident's mood or behavior status .The Licensed Nurse will collaborate with the healthcare practitioner, family, resident, Responsible Party, and/or IDT (an interdisciplinary team, a group of health care professionals with various areas of expertise who work together toward the goals of the resident) members. To identify the contributing factors related to the resident's mood/behavior and the non-medication interventions to be implemented .The Behavior Management/Psychoactive Review Committee will review the following and make recommendations based on resident's need:</p> <ul style="list-style-type: none"> <li>- The effectiveness of non-medication interventions;</li> <li>- Continued use of Psychoactive medication;</li> <li>- Possible nonpharmacological alternatives .</li> </ul>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50012</p> <p>Based on observation, interview and record review, the facility failed to provide one of three sampled residents (Resident 206) with meals that accommodated the resident's food preferences by failing to ensure Resident 206 received coffee with his meal.</p> <p>This deficient practice made Resident 206 feel angry and upset.</p> <p>Findings:</p> <p>During a review of Resident 206's Admission Record, indicated Resident 206 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a broad term for any brain disease that alters brain function), below the left knee amputation, type 2 diabetes (a metabolism disorder that affects the body's ability to use blood sugar) unspecified severe protein-calorie malnutrition (occurs when not enough protein and calories are consumed or metabolized, resulting in muscle loss) sepsis (a life-threatening complication of an infection) and dysphagia (difficulty in swallowing), muscle weakness and visual loss for both eyes.</p> <p>During a review of Resident 206's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 5/29/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was mildly impaired, and required supervision or touching assistance with bed mobility transferring, ambulation, dressing, toileting, and personal hygiene.</p> <p>During a review of Resident 206's History and Physical (H&amp;P), dated 5/25/2024, indicated, Resident 206 had the mental capacity to make medical decisions.</p> <p>During a review of Resident 206's Dietary Profile, dated 5/29/2024 at 2:55 PM, indicated Resident 206 liked coffee and juice with meal. The Dietary Profile indicated food preferences will be honored.</p> <p>During a review of Resident 206's diet order, dated 6/9/2024, indicated an order for CCHO (consistent, constant, or controlled carbohydrate diet-is a medical nutrition therapy often used for managing blood sugar levels) large portion diet, mechanical soft texture, regular/thin consistency, fortified (added vitamins and minerals that are not naturally present in those foods).</p> <p>During a concurrent observation and interview on 7/9/2024 at 10 AM, in Resident 206 room, Resident 206 was sitting in his wheelchair, teary eyed, and with a breaking voice stated he did not receive coffee with his breakfast as he preferred. Resident 206 stated not receiving coffee with breakfast made him very upset, frustrated, and angry. Resident 206 stated that he had a hard time swallowing his food without coffee and that the warm coffee helped him swallow his food. Resident 206 stated that he requested a cup of coffee, and it took very long time for them to bring the coffee. Resident 206 stated his food was cold by the time he received the cup of coffee. Resident 206 stated he did not eat much for breakfast, which was not good for his health.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 7/10/2024 at 12:47 PM, with Resident 206 in Resident 206's room. Resident 206 appeared upset and stated the food was still a problem. Resident 206 stated that food preferences were not being considered because he did not receive coffee with his meals. Resident 206 stated, I am very hungry I did not eat much this morning. I want to enjoy a warm meal. Resident 206's meal tray-card did not indicate coffee as his preference.</p> <p>During an interview on 7/10/2024 at 1 PM, the Dietary Services Supervisor (DSS) stated he goes to each individual resident and asks them about their food preferences, dislikes, and allergies within 72 hours of admission. The DSS stated that it was very important to grant the residents preferences. The DSS stated that meal tray-card should indicate allergies, dislikes, and preferences and should be granted as much as possible.</p> <p>A review of the facility policy and procedure revised on 3/2021 titled Dietary Profile and Resident Preference Interview indicated, Residents preferences will be reflected in the medical record and tray-card and updated in a timely manner.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42307</p> <p>Based on observation, interview and record review, the facility failed to follow safe and proper storage practices in one of one kitchen (Kitchen 1) in accordance with professional standards for food service safety and the facility's policy and procedure (P&amp;P) by failing to:</p> <ol style="list-style-type: none"> <li>a. Ensure food items in Kitchen 1 were labeled/dated.</li> <li>b. Ensure dishware/kitchenware were stored under sanitary conditions.</li> <li>c. Ensure food was stored in a sanitary manner to prevent growth of microorganisms that could cause food-borne illnesses (illness caused by food contaminated with infectious organisms) for one of three sample residents (Resident 36) when Resident 36's yogurt and opened nutritional shake were left out at room temperature for more than two hours inside Resident 36's room.</li> </ol> <p>These deficient practices had the potential to affect the quality and palatability of food given to the residents could result in serious complications caused by food borne illness.</p> <p>Findings:</p> <p>a-b. During a concurrent observation and interview on [DATE] at 7:52 AM, with the Director of Nutritional Services (DNS) during the initial tour of Kitchen 1, the following were observed:</p> <ol style="list-style-type: none"> <li>1. an opened, unlabeled/undated five (5) lb. (pound, a unit of weight) Sysco Ground Black Pepper, with a marking [DATE] on the lid, manufacturer's red date stamp was scratched off and not legible, on the spice shelf.</li> <li>2. three (3) plastic tote box storage bins with clean tulip bowls stacked up, one (1) plastic tote box storage bin with clean 3-inch dessert plates stacked up and pots and strainers stored on the bottom rack in the Dry Line Area. The dishware, pots, and strainers were not stored inverted and were left uncovered.</li> <li>3. an opened unlabeled/undated box that contained multiple packages of Kellogg's Eggo frozen waffles inside the walk-in refrigerator.</li> <li>4. an unlabeled/undated plastic bag of frozen diced chicken with freezer burns (gray, brown in color) located inside the freezer.</li> </ol> <p>The DNS stated, the facility put receive date when the items were received, and once food items were opened. The DNS stated the facility was to put open date and use by date to ensure food items were kept within the shelf life (the length of time that a commodity may be stored without becoming unfit for use or consumption) and expectancy. The DNS stated, if the food items were expired, the food items were a hazard and could potentially cause someone to get sick, and potentially affect the flavor too.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview on [DATE] at 8:12 AM, with the [NAME] (CK) and the Dietary Aide (DA) in Kitchen 1, CK stated, food items were supposed to be labeled with open date and use by date as a precaution for everybody and to know if the food item was good or not. The DA stated, it was important to label food items to keep track and know when the food item could be used and when to throw away the food item. The DA stated, if the food items were no longer good and were served, they (residents) might get sick, would not work as far as flavoring. The DA stated if the food item had no label, we (staff) throw it away.</p> <p>During an interview on [DATE] at 12:10 PM, with the Registered Dietician (RD) during a follow up visit to Kitchen 1, the RD stated, dishware was air dried, stored down (inverted) for infection control [purposes], so it's not exposed to surrounding area.</p> <p>During a review of the facility's undated P&amp;P titled, Dry Goods Storage Guidelines, the P&amp;P indicated, the storage length for ground spices that were opened on the shelf was 2 years.</p> <p>During a review of the facility's P&amp;P titled, Food Storage and Handling, effective date [DATE], the P&amp;P indicated, raw meat, poultry, and seafood should be labeled, dated, and stored in refrigerators/freezers. The P&amp;P under the section Frozen Meat, Poultry and Food, indicated, foods should be labeled, dated, and in their original containers if designed for freezing.</p> <p>During a review of the facility's P&amp;P titled, Pot and Pan Cleaning, effective date [DATE], the P&amp;P indicated, invert the pots and pans, and place them on a drying rack or counter.</p> <p>50016</p> <p>c. During a review of Resident 36's Admission Record (AR), dated [DATE], the AR indicated the facility admitted Resident 36 on [DATE] with diagnoses including atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the heart] fire rapidly at the same time), congestive heart failure (a condition that develops when the heart does not pump enough blood for the body's needs), history of falling, and muscle weakness.</p> <p>During a review of Resident 36's Minimum Data Set (MDS, an assessment and screening tool), dated [DATE], the MDS indicated Resident 36's cognition was severely impaired and required supervision or touching assistance for activities of daily living.</p> <p>During an observation on [DATE] at 9:35 AM, inside Resident 36 Room, one opened strawberry nutritional shake and one yogurt that was four (4) ounces (oz, a unit of weight measurement) were observed and both items had labels dated [DATE] evening snack and were located on top of Resident 36's bedside table.</p> <p>During an observation on [DATE] at 11:41 AM, an unidentified staff gave Resident 36 a strawberry shake and one yogurt four (4) oz labeled dated [DATE] AM snack and placed on Resident 36's bedside table next to the older opened strawberry nutritional shake and one yogurt with label dated [DATE]. Resident 36 was observed trying to open and eat the yogurt that was dated [DATE] and that had been sitting on the bedside table at room temperature for more than two (2) hours.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 11:45 AM, Registered (RN) 2 stated that the labels on the snacks indicated the date the snack was provided. RN 2 stated she does not know how long the milkshake and yogurt with a label dated [DATE] had been sitting on Resident 36's table. RN 2 stated that the snack dated [DATE] should not be on the table and could potentially be spoiled. RN 2 removed the milk shake and yogurt with the label dated [DATE] and resident kept the milk shake and yogurt with a label dated [DATE] to consume. RN 2 stated that eating spoiled yogurt or milk that's been sitting out for several hours or days can potentially cause a foodborne illness.</p> <p>During an interview on [DATE] at 1:13 PM, Certified Nursing Assistant (CNA) 2 stated that she was Resident 36's CNA the morning of [DATE], however, she did not provide any snacks to Resident 36 that day. CNA 2 stated that the nourishment team distributed the snacks to Resident 36 but was not exactly sure who had passed the snacks out. CNA 2 stated that the milkshake and yogurt with the label date of [DATE] should have been removed, especially after she was provided the same snacks that morning with a label date of [DATE]. CNA 2 stated that milk and yogurt sitting out for several hours or more can cause food poisoning and can cause stomach discomfort.</p> <p>During an interview on [DATE] at 10:51 AM, The Dietary Service Supervisor (DSS) stated that the nourishment snacks were typically passed out by the aides. The DSS stated that the label on the nourishment snacks indicated the date the snack was provided to residents. The DSS stated that when residents refused to consume the snacks, the kitchen staff will refrigerate them for two to three days before they were tossed. The DSS stated that he expected staff to toss out milk or yogurt that had been sitting out at room temperature after one hour and no more than two (2) hours at room temperature, because it can cause a foodborne illness if consumed after that period. The DSS stated that foodborne illnesses can cause stomach aches, nausea and/or vomiting, cramping and diarrhea.</p> <p>During a review of the facility's P&amp;P titled Food Storage and Handling, undated, the P&amp;P indicated that dairy items should be kept under refrigeration until use.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</b></p> <p>Based on observation, interview, and record review, the facility failed to follow infection (the invasion and growth of germs in the body) prevention and control practices for seven of seven sampled residents (Residents 176, 68, 164, 140, 135, 140, 198) by failing to:</p> <p>a. Ensure hand hygiene (procedures that included the use of alcohol-based hand rubs [containing 60%-95% alcohol] or hand washing with soap and water) was offered and provided for two of seven sampled residents (Resident 176 and Resident 68).</p> <p>b. Ensure a bowl of pudding was removed from the table where residents were being fed, for one of seven sampled residents (Resident 140), on 7/8/2024, when Resident 164 dipped Resident 164's used spoon into Resident 140's bowl of pudding and Certified Nursing Assistant 2 (CNA 2) fed Resident 140 the pudding.</p> <p>c. Ensure CNA 2 assisted residents in the dining room on 7/8/2024 and performed hand hygiene prior to touching resident food containers-dishes, for three of seven sampled residents (Residents 135, 164, and 140), with CNA 2's bare hands.</p> <p>d. Ensure a nasal cannula (device used to deliver supplemental oxygen placed directly on a resident's nostrils) tubing was stored in a sanitary manner for continued resident use of the equipment and failed to ensure the tubing did not touch the floor for one of seven sampled residents (Resident 198).</p> <p>These deficient practices placed Residents 176, 68, 164, 140, 135, 140 and 198 at greater risk of contracting infections and the potential for the spread of germs throughout the facility and physical declines to the residents. Additionally, the failure resulted in contamination Resident 198's care equipment and placed Resident 198 at risk for infection.</p> <p>Findings:</p> <p>a. During a review of Resident 176's Admission Record (AR), the AR indicated, Resident 176 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) with mood disturbance, unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and heart failure, unspecified.</p> <p>During a review of Resident 176's undated History and Physical Examination (H&amp;P), the H&amp;P indicated, Resident 176 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 176's Minimum Data Set (MDS, an assessment and screening tool), dated 6/25/2024, the MDS indicated, Resident 176's cognition (ability to think and process information) was severely impaired. The MDS indicated, Resident 176 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, toileting hygiene and personal hygiene.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555852	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Park Avenue Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1550 North Park Avenue Pomona, CA 91768	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 68's AR, the AR indicated, Resident 68 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (adult onset too much sugar in the blood) with diabetic chronic kidney disease (a gradual loss of kidney function over time), immunodeficiency (a state in which the immune system's ability to fight infectious diseases and cancer is compromised) due to conditions classified elsewhere and sepsis (a life-threatening complication of an infection), unspecified organism.</p> <p>During a review of Resident 68's MDS, dated [DATE], the MDS indicated, Resident 88's cognitive status was moderately impaired. The MDS indicated, Resident 68 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity. helper assists only prior to or following the activity) with oral hygiene and personal hygiene.</p> <p>During a review of Resident 68's H&amp;P, dated 5/18/2024, the H&amp;P indicated, Resident 68 had the capacity to make decisions (a clinical determination that refers to whether a patient has the mental capability to understand relevant information.)</p> <p>During a concurrent observation and interview on 7/8/2024 at 12:11 PM, staff were observed delivering lunch trays to resident rooms, the staff did not provide hand hygiene or reminded residents to wash their hands. Resident 176 was sitting up at edge of bed as staff (unnamed) delivered Resident 176's lunch tray. Resident 176 started eating and stated, staff did not tell, us to wash our hands.</p> <p>During an interview on 7/8/2024 at 12:31 PM, with Licensed Vocational Nurse 10 (LVN) 10, LVN 10 stated, staff used sanitary wipes for residents before and after meals. LVN 10 stated, staff were to anticipate residents' needs because of their behavior, and staff were supposed to provide hand hygiene even if the residents did not ask. LVN 10 stated, staff were supposed to remind residents to do hand hygiene for infection control [purposes], for their health, so they don't get disease, infection[s].</p> <p>During a concurrent observation and interview on 7/11/2024 at 9:03 AM. with Resident 68, Resident 68 was sitting up in bed and finishing breakfast. Resident 68 stated, staff did not tell or offer hand hygiene to Resident 68, not even a wash towel. Resident 68 stated, Resident 68 could not reach Resident 68's wipes kept in Resident 68's nightstand. Resident 68 stated, not doing hand hygiene made Resident 68 feel not good cuz I always like to clean my hands even before this COVID [COVID-19, a mild to severe respiratory illness that spread from person to person].</p> <p>During an interview on 7/11/2024 at 12:32 PM, with Infection Preventionist (IP) 1, IP 1 stated, residents should be provided with hand hygiene before meals and after using the bathroom. IP 1 stated residents who were not able to go to the restroom should be provided with hand wipes or wash cloth with soap and water. IP 1 stated, hand hygiene was important to prevent residents from getting any type of infections or spreading infections, for infection control [purposes].</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Infection Control - Policies and Procedures, revised 1/1/12, the P&amp;P indicated, The Facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P, titled, Hand Hygiene revised 9/1/20, the P&amp;P indicated, The Facility considers hand hygiene as the primary means to prevent the spread of infections. The P&amp;P indicated, Facility staff, healthcare personnel (HCP), Residents, visitors, and volunteers must perform hand hygiene to prevent the transmission of HAIs (healthcare associated infections). The P&amp;P indicated, before eating was one of the following situations requiring appropriate hand hygiene.</p> <p>36924</p> <p>b-c. During a review of Resident 164's MDS, dated [DATE], the MDS indicated Resident 164 had severe cognitive (processes of thinking and reasoning) impairment. The MDS indicated Resident 164 required set up and cleaning assistance with eating and substantial/maximal assistance with personal hygiene.</p> <p>During a review of Resident 164's AR, the AR indicated Resident 164 was readmitted to the facility on [DATE] with diagnoses that included acute (sudden) respiratory failure (inadequate lung gas exchange), acute pulmonary edema (buildup of fluid in the lungs), and unspecified dementia (lose ability to think, remember, learn, make decisions, and solve problems).</p> <p>During a review of Resident 164's H&amp;P, dated 4/5/2024, the H&amp;P indicated Resident 176 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 140's AR, the AR indicated Resident 140 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (progressive disease destroying memory and mental functions) and dementia (lose ability to think, remember, learn, make decisions, and solve problems).</p> <p>During a review of Resident 140's H&amp;P, dated 10/10/2023, the H&amp;P indicated Resident 140 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 140's MDS, dated [DATE], the MDS indicated Resident 140 had severe cognitive impairment. The MDS indicated Resident 140 was dependent for eating and personal hygiene.</p> <p>During a review of Resident 135's AR, the AR indicated Resident 135 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, essential hypertension (high blood pressure with no distinct cause), and bipolar disorder (mood swings ranging from depressive lows to manic highs).</p> <p>During a review of Resident 135's MDS, dated [DATE], the MDS indicated Resident 135 had severe cognitive impairment. The MDS indicated Resident 135 required set up and cleaning assistance with eating.</p> <p>During a review of Resident 135's H&amp;P, dated 6/27/2024, the H&amp;P indicated Resident 135 did not have the capacity to make decisions (ability to make one's own decisions).</p> <p>During a dining observation in Dining room [ROOM NUMBER] (DR 1), on 7/8/2024, at 11:58 AM, seven residents were observed seated around four-squared shaped tables, CNA 1 was observed assisting the residents with meal tray set up and eating.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Park Avenue Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1550 North Park Avenue Pomona, CA 91768	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation, on 7/8/2024, 12:18 PM, Resident 164 was observed placing Resident 164's spoon into Resident 140's bowl of rice pudding. Resident 164 pulled the spoon out and put the spoon in Resident 164's mouth and took a bite of the pudding in front of CNA 1. CNA 1 took the spoon away from Resident 164, put the spoon into the bowl that contained Resident 140's pudding, and moved the bowl of pudding from Resident 140's middle of the food tray to the side of Resident 140's food tray. CNA 1 did not remove the dish of rice pudding from Resident 140's food tray or from the table.</p> <p>During an observation on 7/8/2024, at 12:20 PM, CNA 2 was observed assisting Resident 140 with eating. CNA 2 touched Resident 135's milk container, touched Resident 164's dish that contained rice pudding, and touched Resident 140's 8 oz. (ounce, unit of weight) glass of red liquid [juice]. CNA 2 did not perform hand hygiene prior to assisting residents and prior to touching resident food containers-dishes.</p> <p>During an observation on 7/8/2024, at 12:38 PM, CNA 2 came to assist CNA 1 and sat down to feed Resident 140. CNA 2 took Resident 140's bowl of pudding and fed Res 140 the pudding, CNA 2 took the spoon and mixed a spoon full of pudding with other food items located on Resident 140's food tray.</p> <p>During an interview, on 7/8/2024, at 12:50 PM, CNA 2 stated CNA 2 took the bowl of pudding and began to feed the pudding to Resident 140.</p> <p>During an interview on 7/8/2024, at 12:56 PM, CNA 1 stated CNA 1 needed more staff to assist and to monitor the residents in dining room.</p> <p>During an interview on 7/8/2024, at 12:58 PM, CNA 1 stated the problem with feeding Resident 140 the rice pudding was due to Resident 164 putting Resident 164's spoon inside Resident 140's pudding, CNA 1 stated [this action] was related to infection control.</p> <p>During an interview, on 7/8/2024, at 1:03 PM, with Registered Nurse 1 (RN 1), RN 1 stated the importance of not cross contaminating (process by which bacteria can be transferred from one area to another) was to prevent the spread of infection and diseases. RN 1 stated hand hygiene was the most important [intervention to prevent cross contamination].</p> <p>During a concurrent interview, on 7/8/2024, at 1:15 PM, with Licensed Vocational Nurse 7 and 8 (LVN 7 and LVN 8), at the nurse's station, LVN 7 stated there was cross contamination when Resident 164 put Resident 164's spoon in Resident 140's bowl of pudding and when Resident 140 was fed from the bowl. LVNs 7 and 8 stated, the importance of maintaining infection control [practices] was to keep everyone free from germs, if one resident got sick, we're [the facility] going to get the other one sick.</p> <p>During a review of the facility's P&amp;P, titled, Infection Control- Policies &amp; Procedures, revised January 2012, the P&amp;P indicated the facility's infection control policies and procedures are intended to facilitate a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infection.</p> <p>50016</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Park Avenue Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1550 North Park Avenue Pomona, CA 91768	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. During a review of Resident 198's AR, the AR indicated the facility admitted Resident 198 on 2/27/2024, with diagnoses including pneumonia (an infection of the lungs that may be caused by bacteria, viruses, or fungi), acute and chronic respiratory failure (a serious condition that makes it difficult to breathe on your own), generalized muscle weakness, and end stage renal disease (the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own).</p> <p>During a review of Resident 198's MDS, dated [DATE], the MDS indicated Resident 198's cognition was moderately impaired and required substantial/maximal assistance with activities of daily living. MDS indicated Resident 198 had an active diagnosis of acute and chronic respiratory failure with hypoxia (low levels of oxygen in body tissues).</p> <p>During a review of Resident 198's physician order, dated 4/1/2024, indicated to provide oxygen at two (2) liters per minute via nasal cannula to keep oxygen saturation (the amount of oxygen that was circulating in the blood, normal range 95 to 100 % [percent- a part per hundred]) above 95% as needed.</p> <p>During an observation on 7/8/2024 at 10 AM, Resident 198's oxygen nasal cannula tubing connected to the oxygen concentrator (a medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen) was found directly on the floor under the bedside table.</p> <p>During an interview on 7/8/2024 at 10:10 AM, CNA 1 stated that the oxygen nasal cannula tubing was on the floor. CNA 1 stated that the oxygen nasal cannula should be stored in the plastic bag located at Resident 198's bedside and not on the floor to prevent bacterial growth. CNA 1 stated that oxygen nasal cannula tubing on the floor can potentially compromise Resident 198's health and can potentially cause an infection.</p> <p>During an interview on 7/9/2024 at 10:45 AM, IP 1 stated that the oxygen nasal cannula tubing should never be directly touching the floor and should be properly stored in the plastic bag at the bedside. IP 1 stated the oxygen nasal cannula tubing in Resident 198 Room was susceptible to bacterial pathogens (harmful species that cause bacterial infections and contagious diseases that result in many serious complications) and could have put Resident 198 at risk for an infection.</p> <p>During a review of the facility's P&amp;P titled Oxygen Therapy, dated revised 11/2017, the P&amp;P indicated oxygen is administered under safe and sanitary conditions to meet resident needs.</p> <p>During a review of the facility's P&amp;P titled Infection Control-Policies &amp; Procedures , revised 1/1/2012, the P&amp;P indicated staff are trained on the infection control policies and procedures upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</b></p> <p>Based on interview and record review, the facility failed to offer and provide influenza ([flu] a common, sometimes deadly infection of the nose, throat and lungs) and pneumococcal (a serious bacterial lung infection) vaccinations (a simple, safe and effective way of protecting you against harmful diseases, before you come into contact with them), and ensure education was provided to three of five sampled residents (Resident 14, Resident 196 and Resident 200) and or representatives regarding the risk and benefits and the potential side effects of the vaccinations and whether the resident received the influenza and pneumococcal vaccines, could not receive the vaccines due to medical contraindications, or refused the vaccines, as indicated in the facility's policy and procedures (P&amp;P), titled Influenza Prevention and Control and Pneumococcal Vaccination - Pneumovac or Pneumococcal conjugate vaccines.</p> <p>This deficient practice placed Residents 14, 196, and 200 at greater risk of acquiring, transmitting, or experiencing complications from the influenza and/or pneumococcal disease.</p> <p>Findings:</p> <p>During a review of Resident 14's Admission Record (AR), the AR indicated, Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) unspecified severity, with other behavioral disturbance, personal history of COVID-19 (a mild to severe respiratory illness that spread from person to person) and encounter for immunization (code or medical classification employed when a patient seeks out a healthcare provider to receive an immunization).</p> <p>During a review of Resident 14's History and Physical Examination (H&amp;P), dated 1/3/2024, the H&amp;P indicated, Resident 14 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 14's Minimum Data Set (MDS, an assessment and screening tool), dated 6/13/2024, the MDS indicated, Resident 14's cognitive (ability to think and process information) status was severely impaired.</p> <p>During a review of Resident 196's AR, the AR indicated, Resident 196 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including sepsis (a life-threatening complication of an infection), unspecified organism, pneumonia (an infection that affects one or both lungs) and personal history of COVID-19.</p> <p>During a review of Resident 196's H&amp;P, dated 5/13/2024, the H&amp;P indicated, Resident 196 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 196's MDS, dated [DATE], the MDS indicated Resident 14's cognitive (ability to think and process information) skills for daily decision making were severely impaired.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 196's undated Pneumococcal Vaccination, Consent or Refusal (PVCR), the PVCR indicated, the form was blank. The PVCR indicated, A signed and completed copy of this consent must be filed in the resident's medical record.</p> <p>During a review of Resident 200's AR, the AR indicated, Resident 200 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified dementia, unspecified severity, with psychotic disturbance (a severe mental disorder characterized by a disconnection from reality), and pneumonia, unspecified organism and sepsis, unspecified organism.</p> <p>During a review of Resident 200's PVCR, dated 5/19/2024, the PVCR indicated, the form was incomplete. The PVCR indicated, A signed and completed copy of this consent must be filed in the resident's medical record.</p> <p>During a review of Resident 200's H&amp;P, dated 6/12/2024, the H&amp;P indicated, Resident 200 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 200's MDS, dated [DATE], the MDS indicated, Resident 200's cognitive status was moderately impaired.</p> <p>During a concurrent interview and record review on 7/10/2024 at 9:48 AM with Infection Preventionist 1 (IP 1) and IP 2, Resident 14, 196 and 200's medical records and the facility's Residents Influenza Vaccine 2023-2024 (RIV) white colored binder were reviewed. IP 1 stated IP 1 could not find any documentation that contained information/education and/or administration that indicated the flu vaccine was provided to Resident 200 or [discussed with the] representative. IP 1 could not find any documentation or a PVCR for Resident 14. IP 1 stated, it was important to provide education and offer the vaccine to residents (in general) to prevent the residents from getting sick from the flu and from pneumonia because the vaccine was an added layer of protection from the virus (a very simple microorganism that infects cells and may cause disease) or bacteria (microscopic organism that can infect hosts like humans, plants or animals). IP 1 stated, residents or representatives were provided with education and offered vaccinations upon admission and within five (5) days. IP 2 stated, it was important to provide and offer vaccinations to minimize the spread of infections inside the facility.</p> <p>During a review of the facility's P&amp;P titled, Influenza Prevention and Control date revised 9/10/2020, the P&amp;P indicated, to prevent and control the spread of influenza in the facility, the facility will follow infection prevention and control policies and procedures to minimize the risk of residents acquiring, transmitting or experiencing complications from influenza. The P&amp;P indicated, the resident's medical record will include documentation that indicates, at a minimum, the resident or the resident's representative was provided education regarding the risk and benefits and potential side effects of the influenza vaccination and whether the resident received the influenza vaccine, could not receive the vaccine due to a medical contraindication or refused the vaccine.</p> <p>During a review of the P&amp;P titled, Pneumococcal Vaccination - Pneumovac or Pneumococcal conjugate vaccines effective date 5/4/2023, the P&amp;P indicated, upon admission, the facility obtained the pneumococcal history of all residents and based on the resident's pneumococcal vaccination history, offer the appropriate vaccine, following the recommended schedule (unless the vaccination is medically contraindicated, or the resident has already been vaccinated.)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</b></p> <p>Based on interview and record review, the facility failed to offer and provide the COVID-19 (a mild to severe respiratory illness that spread from person to person) immunization (a process by which a person becomes protected against a disease [a disorder of structure or function in a human, animal, or plant]) and ensure education was provided to two of five sampled residents (Resident 196 and 200) and or their representatives regarding the risk and benefits and the potential side effects of the vaccination and whether the residents received the COVID-19 vaccines, could not receive the vaccines due to medical contraindications, or refused the vaccines.</p> <p>This deficient practice had the potential for Resident 196 and 200 to not be provided the opportunity to decline or be currently immunized to lower risk of acquiring, transmitting, or experiencing complications from COVID-19.</p> <p>Findings:</p> <p>During a review of Resident 196's AR, the AR indicated, Resident 196 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including sepsis (a life-threatening complication of an infection), unspecified organism, pneumonia (an infection that affects one or both lungs) and personal history of COVID-19.</p> <p>During a review of Resident 196's H&amp;P, dated 5/13/2024, the H&amp;P indicated, Resident 196 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 196's MDS, dated [DATE], the MDS indicated Resident 14's cognitive (ability to think and process information) skills for daily decision making were severely impaired.</p> <p>During a review of Resident 200's AR, the AR indicated, Resident 200 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified dementia, unspecified severity, with psychotic disturbance (a severe mental disorder characterized by a disconnection from reality), and pneumonia, unspecified organism and sepsis, unspecified organism.</p> <p>During a review of Resident 200's H&amp;P, dated 6/12/2024, the H&amp;P indicated, Resident 200 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 200's MDS, dated [DATE], the MDS indicated, Resident 200's cognitive status was moderately impaired.</p> <p>(continued on next page)</p>

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 7/10/2024 at 9:48 AM with Infection Preventionist 1 (IP 1) and IP 2, Resident 196 and 200's medical records and the facility's Residents COVID Vaccine (RCV) black colored binder was reviewed. The medical records indicated Resident 196 last received the COVID-19 vaccine on 12/7/2022 and Resident 200 last received the vaccine on 1/25/2022. IP 1 could not find any documentation in the RCV binder that indicated Resident 196 and 200 or their representatives were provided information/education or that indicated administration of the updated COVID-19 vaccine. IP 1 stated, it was important to provide education and to offer the updated COVID-19 vaccine to residents (in general) to prevent the residents from getting sick from COVID-19 and stated the vaccine was an added layer of protection from the virus. IP 2 stated, it was important to provide and offer the vaccination to minimize the spread of infection inside the facility.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, COVID-19 Vaccination Program, revised 3/15/2022, the P&amp;P indicated, The facility will offer SARS-CoV-2 vaccinations (including additional and booster doses) to all Residents. They will be encouraged but are not required to be vaccinated or boosted. The P&amp;P indicated, under Documentation of Vaccination section, The vaccine provider is responsible for submitting all required documentation to the LHD and other local, state and federal agencies. The staff member who presents the EUA fact sheet or VIS to the Resident (or responsible party) and receives the declination or agreement for the vaccine is the person responsible for documenting either answer into the Resident's medical record.</p>		