STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055060	A. Building B. Wing	06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Post Acute Care	12121 Santa Monica Boulevard Los Angeles, CA 90025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to: 1. Ensure one of 19 sampled residents (Resident 64) was treated with respect and dignity by failing to close the privacy curtain to provide visual privacy while staff was rendering care and giving bed bath, and 2. Protect the residents' privacy and dignity by not placing a covering over the urinary catheter (a soft hollow tube which is passed into the bladder to drain urine, for persons who cannot empty their bladder in the usual way) drainage bag for two of 19 sampled residents (Residents 64, 67 and 118). These deficient practices had the potential to affect Residents 64, 67, and 118's sense of self-worth and self-esteem. Findings: 1. A review of Resident 64's Face Sheet (Admission Record) indicated Resident 64 was readmitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body) and heart disease. A review of Resident 64's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 05/11/2021, indicated Resident 64 had severe impairment in cognition for daily decision making. During an observation on 05/25/2021 at 10:35 a.m., the Caregiver (CG 1) was observed at bedside providing resident care and bed bath to Resident 64, privacy curtain was not pulled and Resident 64's upper thigh to waist was exposed. During an interview with CG 1, on 05/25/2021 at 10:50 a.m., stated she closed privacy curtain when she came in, but someone opened it up again. When asked what the facility's policy regarding privacy curtain, CG 1 stated curtain was supposed to be close when providing care to residents to provide privacy. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Staff and Development/Infection Preventionist (DSD/IP), The DSD/IP stated that caregivers in the facility are instructed to provide privacy while providing care by closing the curtain to all residents. A review of the facility's policies and procedures titled, Resident Rights, with revised date of 01/01/2012, indicated employees are to treat all residents with kindness, respect and dignity and honor the exercise of residents' rights. 40541 2. A review of Resident 67 's Face Sheet indicated Resident 67 was admitted to the facility on [DATE], with diagnoses including paraplegia (complete or partial loss of movement or feeling in the lower half of the body), muscle weakness, and retention of urine. A review of the Resident 67's MDS, dated [DATE], indicated Resident 67's cognition was intact. Resident 67 used a manual wheelchair for mobility, required limited assistance with bed mobility, eating and personal hygiene, and total dependence for transfers, dressing, toilet use, and bathing. During an observation on 05/24/2021, at 10:35 a.m., Resident 67 's catheter drainage bag was not covered with a privacy covering. During a concurrent observation, a privacy covering was attached to Resident 67's bed, not being used. During an observation and a concurrent interview with the Director of Nursing (DON), on 5/24/2021, at 5:40 p. m., the DON confirmed the findings and stated catheter drainage bag was not covered with a privacy covering. The DON further stated the catheter drainage bag should be covered with the privacy covering for dignity. A review of Resident 118's Face Sheet indicated Resident 118 was admitted to the facility on [DATE], with diagnoses including hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) following cerebral infarction (also known as a stroke- damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, urogenital implants (injections of material into the urethra [a tube that drains urine from the bladder out of the body] to help control urine leakage [urinary incontinence] caused by a weak urinary sphincter [The sphincter is a muscle that allows your body to hold urine in the bladder]) and muscle weakness. A review of Resident 118's History and Physical Form, dated 05/20/2021 indicated Resident 118's cognition was intact and had the capacity to understand and make decisions. During an observation on 05/24/2021, at 9:05 a.m. Resident 118 's catheter drainage bag was not covered with a privacy covering. During a concurrent observation, privacy covering was attached to Resident 118's bed, not being used. During an observation and a concurrent interview with Licensed Vocational Nurse 5 (LVN 5), on 05/24/2021, at 9:13 a.m., LVN 5 confirmed the findings and stated Resident 118's catheter drainage bag should be covered with the privacy covering for dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures titled Indwelling Catheter, Nursing Manual - Bowel & Bladder, with revised date of 09/01/2014, indicated, Catheter care .the resident's privacy and dignity will be protected by placing cover over drainage bag. A review of the facility's policy and procedures titled Resident Rights, with revised date of 01/01/2012, indicated, The purpose was to promote and protect the rights of all residents at the facility .Employees are to treat all residents with .dignity .privacy and confidentiality.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43601 Based on observation, interview and record review the facility failed to ensure staff notify the attending physician, and document treatment refusal for one of five sampled residents (Resident 1). This deficient practice, resulted in Resident 1 not receiving treatment ordered for nine days and had the potential for impaired and or worsening skin integrity, and a delay in physician treatment orders and or interventions. Findings: A review of the Face Sheet (Admission Record), indicated the facility admitted Resident 1 on 10/26/2020 with diagnoses including diabetes (a chronic condition that affects (a condition that occurs when the body can't use glucose [sugar] normally), and sepsis (a life-threatening complication of an infection). A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 03/03/2021, indicated Resident 1 had moderate cognitive (ability to learn, remember, understand, and make decisions of daily living) impairment. During record review with LVN 5 on 05/25/2021 at 7:40 a.m., Resident 1's Treatment Administration Record (TAR) order section to cleanse the upper abdomen and periumbilical was blank from 05/19/2021 to 05/22/2021. In a concurrent interview LVN 5 was not able to explain the meaning of blank on Resident1's TAR, nor state how to document if Resident 1 refused treatment. However, LVN 5 stated it must have been overlooked. During record review of the Resident 1's Progress notes, there was no documentation to indicate the charge nurse or DON, notified the attending physician that Resident 1 refused treatment from 5/19/2021 to 5/28/2021. A review of the facility's policy and procedures titled, Refusal of Treatment revised on 01/01/2012, indicated the Charge Nurse or DNS will document information relating to the refusal in the resident's medical record . with the date and time the attending physician was notified and his or her response.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43601 Based on observation, interview and record review the facility failed to protect confidential information for one of 19 sampled residents (Resident 17). This deficient practice had the potential to result in the unauthorized release of Resident 17's personal information. Findings: A review of Resident 17's Face Sheet indicated Resident 17 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (depressed mood) and diabetes mellitus (uncontrolled high blood sugar) During an observation on 05/27/2021 at 2:43 p.m., in nurses' station, the Minimum Data Set (MDS)/Licensed Vocational Nurse (LVN) left nurses station with Resident 17's computer chart open to Resident 17's care plan. During an observation on 05/27/2021 at 2:45 p.m., in nurses' station, the Physical Therapist Assistant (PTA) went to nurses' station over to nurses station phone next to open computer with Resident 17's care plan visible. During an observation on 05/27/2021 at 2:48 p.m., in nurses station, the MDS/LVN returned to nurses station and computer remains open with Resident 17's care plan visible. During an observation on 05/27/2021 at 2:52 p.m., in nurses station, the Certified Nurse Assistant (CNA) 6 was washing hands with Resident 17's care plan visible. During a concurrent observation and interview with the Administrator, on 05/27/2021 at 2:55PM in nurses' station , the Administrator stated computer has resident information protected by Health Information Protection and Portability Act (HIPPA) visible. The Administrator confirmed the findings and stated sorry and turned off the computer screen. During an interview with MDS/LVN, on 05/28/2021 at 9:17AM, the MDS/LVN stated he was in-serviced regarding HIPPA at the time of hire. The MDS/LVN further stated he not been in-serviced on HIPPA since last year. The MDS/LVN further stated he should have minimized or covered the resident information because that was personal information. The MDS/LVN further stated leaving the computer open with Resident 17's personal information visible to others can result in others seeing resident private information. During an interview with the Director of Nursing (DON), on 05/28/2021 at 12:10PM, the DON stated it was not appropriate for Resident 17 's care plan to be left visible in the nurse's station. The DON further stated it was against HIPPA regulations as it was Resident 17's private information that was visible. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Staff Development (DSD), on 06/01/2021, at 1:25PM, the DSD stated HIPPA in-service was done annually. The DSD further stated MDS/LVN had not done his annual HIPPA in-service. A review of facility's policy and procedures titled, Notice of Privacy Practices, revised on 12/01/2012, indicated facility staff will be trained on the privacy practices of the facility upon hire and annually. A review of facility's in-service sign in sheet for Confidentiality of Patient's information from 03/22/2021 to 03/24/2021 did not include MDS/LVN name.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43601 Based on observation, interview, and record review, the facility failed to provide a comfortable sound level per facility's policy for three of three sampled residents (Residents 34, 16 and 38). Residents 34, 16, and 38, were affected by the ongoing sound of the door alarms. This deficiency resulted in residents being exposed to loud and annoying alarms. Findings: 1. A review of Resident 16's Admission Record indicated the facility readmitted the resident on 10/13/2020 with diagnoses that included fibromyalgia (a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory and mood issues) and insomnia (a sleep disorder in which the person has trouble falling and/or staying asleep). A review of Resident 16's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 3/2/2021, indicated the resident had intact cognitive skills for daily decision-making. During an interview on 05/24/2021 at 11:10 a.m., Resident 16 stated the alarm is loud and it goes on all day even at night and she is unable to sleep. On 05/24/2021 at 10:16 a.m., the door alarm sounded after a staff opened the door for about one minute and was not turned off. On 05/27/2021 at 6:18 a.m., the door alarm went off after each staff opens the door. On 06/01/2021 at 10:13 a.m., during an interview, Resident 16 stated the alarm was non-stop and drove her crazy. Resident 16 stated she complained to the staff many times but they do not do anything about it. 2. A review of Resident 34's Admission Record indicated the facility admitted the resident on 09/17/2019 with diagnosis including muscle weakness and nicotine dependence. A review of Resident 34's MDS dated [DATE], indicated the resident was able to communicate and make decisions. On 05/25/2021 at 6:48 a.m., outside Resident 34's room, a loud alarm could be heard each time the door was opened. On 05/27/2021 at 6:50 a.m., during an interview, Licensed Vocational Nurse 4 (LVN 4) stated the exit doors were alarmed and went off each time the door was opened. LVN 4 stated staff use the door to take out the soiled linen, but the staff was supposed to turn off the alarm right away. On 05/27/2021 at 6:52 a.m., during an interview, LVN 4 stated the residents stated the alarms were annoying but it was morning and breakfast was coming anyways so they had to get up regardless. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/27/2021 at 8:59 a.m., Resident 34 stated exit alarms were annoying, loud, and rang since 5 a.m. interrupting her sleep. 3. On 05/25/2021 at 1:37 p.m., during an interview, Resident 27 stated alarms kept her up all night. A review of Resident 27's Admission Record indicated the facility admitted the resident on 11/30/2020 with diagnoses including of weakness and bradycardia (slow heart rate). A review Resident 27's MDS, dated [DATE], indicated the resident could understand and make decisions. A review of the facility's policy and procedures titled, Resident Rights revised 01/01/2012, indicated each resident was allowed to choose activities, schedules, and health care consistent with his or her interests, assessments, and plan of care, including: sleeping, eating schedules. A review of the facility's policy and procedures titled, Resident Rooms and Environment revised 01/01/2012, indicated the facility would provide residents with a personalized, homelike atmosphere, paying close attention to .comfortable noise levels.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43239 Based on interview and record review, the facility failed to ensure residents' proposed transfer/discharge notifications were sent to the Office of the State Long-Term Care Ombudsman (an advocacy group for residents in the nursing homes) for two of three sample residents (Residents 3 and 68). This deficient practice had the potential to result in unsafe discharges and denied the residents the right to appeal discharges. Findings: 1. A review Resident 3's Admission Record, indicated the facility admitted the resident on 11/03/2020, with diagnoses including of Hypertension and Acute Myocardial Infarction (or heart attack. A heart attack is a life-threatening condition that occurs when blood flow to the heart muscle is abruptly cut off, causing tissue damage). A review of the Admission/Discharge Report indicated the facility discharged Resident 3 on 03/05/2021. On 05/27/2021 at 11:38 a.m., during an interview, the Director of Nursing (DON) stated there was no copy of written notice of Proposed Transfer/Discharge sent to the Ombudsman found in Resident 3 medical chart. The DON stated the facility will send from now on. 43454 2. A review of the Admission Record indicated the facility admitted Resident 68 on 05/06/2021, with diagnoses that including Hypertension (a condition in which the long-term force of the blood against artery walls is high enough that it may eventually cause health problems, such as heart disease), and Chronic Kidney Disease (or the gradual loss of kidney function. In an advanced stage, dangerous levels of fluid, electrolytes and wastes can build up in one's body) A review of the Admission/Discharge Report indicated the facility discharged Resident 68 on 05/09/2021. On 06/01/2021 at 2:12 p.m., during a concurrent interview and record review, the Assistant Director of Nursing (ADON) stated there was no copy of written notice of Proposed Transfer/Discharge sent to the Ombudsman in Resident 68's medical chart. A review of the facility's policy and procedure titled Discharge and Transfer of Residents, revised on 02/2018, did not indicate the facility should notify the Ombudsman prior to a resident's transfer/discharge from the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40541 Based on observation, interview, and record review, the facility failed to develop or implement a careplan for safe storage of cigarettes, lighter, and or crafting materials for two of three sampled residents (Residents 4 and 130). This deficient practice had the potential to not address resident-specific health and safety concerns, prevent decline or injury, and identify the need for supervision for Residents 4 and 130. Findings: a. A review of the Face Sheet (Admission Record) indicated the facility initially admitted Resident 4 on 08/20/2017, and readmitted on [DATE], with diagnoses including atherosclerotic (narrowing of arteries due to plaque buildup on the artery walls) heart disease of native coronary (relating to the arteries which surround and supply the heart) artery without angina pectoris (chest pain). A review of the Resident 4's Minimum Data Set (MDS, a standardized resident assessment and care-screening tool) dated 05/11/2021, indicated Resident 4's cognition (ability to learn, remember, understand, and make decisions of daily living) was intact, required supervision for bed mobility, transfer, walking, eating, toilet use, personal hygiene, and limited assistance with dressing, and extensive assistance with bathing. During an observation on 05/24/2021 at 11:18 a.m., observed Resident 4 sitting on the patio, had a pack of cigarettes, and a lighter, and was smoking without supervision. During an observation on 05/24/2021 at 12:02 p.m., observed Resident 4 with a crafted miniature raft like object made of popsicle sticks, popsicle sticks, different color paint bottles, a metal pipe, needle nose pliers, scissors, and lighter on patio outside of Resident 4's room, and smoking a cigarette without supervision. In a concurrent interview, Resident 4 stated he made crafts using the items observed. Resident 4 lit the bowl of the metal pipe with his lighter and rounded the corners of a popsicle stick using the [NAME] in the bowl of the metal pipe, stating it was the method he used to round the corners of the crafted raft like object. Resident 4 further stated staff were aware he used the items to make crafts. Resident 4 also stated he did not require supervision when making the crafts or when smoking. During an observation with the Director of Staff Development/Infection Preventionist Nurse (DSD/IP) on 05/24/2021, at 4:30 p.m., observed Resident 4 smoking a cigarette on the patio. Resident 4 was also observed with the aforementioned crafting materials and a box cutter without supervision. In a concurrent interview, the DSD/IP confirmed and stated Resident 4 had crafting materials, a box cutter and was smoking and not supervised. During an interview and a concurrent review with Licensed Vocational Nurse 8 (LVN 8) on 05/26/2021, at 1 p. m., LVN 8 stated Resident 4's clinical record did not have a care plan that indicated Resident 4's preference to keep cigarettes, lighter and crafting items with him at all times, and a care plan developed to indicate the resident's preference, and to ensure safe monitoring. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A review of the Face Sheet indicated the facility admitted Resident 130 on 05/19/2021, with diagnoses including lateral malleolus (a bony projection with a shape likened to a hammer head, especially each of those on either side of the ankle) fracture of left fibula (the outer and usually smaller of the two bones between the knee and ankle), generalized muscle weakness, and nicotine dependence, cigarettes. A review of the Resident 130's History and Physical form dated 05/20/2021, indicated Resident 130's cognition was intact and, had the capacity to understand and make decisions. During an interview on 05/24/2021 at 1:17 p.m., Resident 130 stated he was always able to keep his cigarettes and lighter with him at all times. During an observation on 5/24/2021 at 4:27 p.m. observed Resident 130 sitting in his wheelchair smoking a cigarette on the patio without supervision. During an observation with DSD/IP on 05/24/2021, at 4:30 p.m., Resident 130 was smoking a cigarette on the patio without supervision. Resident 130 had a pack of cigarettes and a lighter on his lap. In a concurrent interview, the DSD/IP confirmed and stated Resident 130 was smoking, had a pack of cigarettes and a lighter, and not supervised. During an interview and concurrent review with LVN 8 on 05/26/2021, at 1:07 p.m., LVN 8 stated Resident 130's clinical record did not have a care plan developed for Resident 130's preference to keep his cigarettes and lighter with him at all times, and that a care plan to indicate the resident's preference, and developed to ensure safe monitoring of Resident 130. A review of the facility's policy and procedures titled Comprehensive Person-Centered Care Planning, revised date, 11/2018, indicated to ensure that a comprehensive person centered care plan is developed for each resident. It is the policy of this facility to provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting . safety . needs of residents in to obtain or maintain the highest physical, mental, and psychosocial well-being. Baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. It should address resident-specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions. The baseline care plan must reflect the resident's stated goals and objectives and include interventions that address his or her needs. The baseline care plan will be initiated upon admission by the admitting nurse using the necessary combination of problem specific care plans to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission. A review of the facility's policy and procedures titled Smoking by Residents, revised date, 01/2017, indicated to provide a safe environment for residents, staff, and visitors. Interdisciplinary team (IDT) will develop an individualized plan for safe storage, use of smoking materials, assistance and required supervision, if necessary, of residents who smoke. This is documented on . the resident's plan of care, and discussed with the resident .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43601 Based on observation, interview, and record review, the facility failed to ensure staff assisted dependent residents with activities of daily living (ADL), and unable to carry out personal hygiene and grooming, and were incontinent of bladder and bowel functions (inability to control urination and bowel movements, were not left lying in urine and or bowel (stool) movement for seven of 19 sampled residents (Residents 1, 10, 11, 21, 27, 34, and 318). Thess deficient practices, resulted in Residents 1, 10, 11, 21, 27, 34, and or 318, left lying/sitting in wet/soiled linen and briefs for extended period of time, bed linen dripping urine on the floor, and placed Residents 1, 10, 11, 21, 27, 34, and 318, at risk for lowered self-esteem, urinary tract infection (UTI, infection in any part of the urinary system), hypothermia (a significant and potentially dangerous drop in body temperature), and skin breakdown. Findings: 1. A review of Resident 1's Face Sheet (Admission Record), indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM- a chronic condition that occurs when the body cannot use glucose [sugar] normally), and sepsis (a life-threatening complication of an infection). A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 03/03/2021, indicated Resident 1 had moderate cognitive (ability to learn, remember, understand, and make decisions of daily living) impairment and needed assistance with personal hygiene, toilet use, and bathing. During the initial tour on 05/24/2021 at 9:18 a.m., Resident 1was not groomed and the resident's room had pungent urine smell. Observed underneath Resident 1's bed, was a wet puddle of opaque (not clear) like fluid dripping from Resident 1's blanket and linen, and onto the floor. During an interview with Resident 1, on 05/24/2021 at 1:06 p.m., Resident 1 stated staff did not clean him when wet and would sit in his urine and stools for hours. Resident 1 further stated he was allergic to disposable incontinent brief and did not wear one. Resident 1 stated he used the call light for staff to come and assist him with changing the bed linen and clean him, but staff take a long time to respond to his call for assistance. On 05/25/2021 at 7:18 a.m., during an observation of Resident 1's floor under the bed and concurrent interview with Licensed Vocational Nurse 1 (LVN 1), LVN 1 acknowledged there was a wet puddle underneath Resident 1's bed. LVN 1 stated incontinent residents should be checked frequently. LVN 1 did not know the last time Resident 1 was checked or changed. During an observation on 05/26/2021 at 7:52 a.m., Resident 1's call light was on outside the Resident 1's room above the door. CNA 2 passed by Resident 1's room at 7:54 a.m., did not enter the room to respond to the call light. Restorative Nursing Assistant (RNA)/CNA 2 and CNA 7 passed by Resident 1's room at 7:58 a. m. and did not respond to Resident 1's call light. (continued on next page)

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	055060	A. Building B. Wing	06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/26/2021 at 8:03 a.m., RNA/CNA 2 stated call lights should be answered immediately, and residents should be the priority. 2. A review of Resident 10's Face Sheet, indicated the facility admitted Resident 10 on 04/02/2013, and was readmitted [DATE], with diagnoses including heart failure (a progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and chronic obstructive pulmonary disease (COPD - long term breathing problem). A review of Resident 10's MDS dated [DATE], indicated Resident 10 had severe cognitive impairment. During an interview with Resident 10 on 05/25/2021 at 10:09 a.m., Resident 10 stated staff took a long time to respond to call lights. A review of facility policy titled Communication - Call System revised 01/01/2012, indicated nursing staff will answer call light promptly. 2. A review of Resident 11's Face Sheet indicated Resident 11 was admitted to the facility on [DATE], with diagnoses including Hypertension (a condition in which the long-term force of the blood against artery walls is high enough that it may eventually cause health problems, such as heart disease) and muscle weakness. A review of Resident 11's MDS, dated [DATE] indicated Resident 11 had no cognitive impairment (no confusion, memory problems or problems with judgement). During an observation on 05/24/2021, at 7:00 a.m., Resident 11 activated the call light at 7:00a.m., nurse answered and was told about soiled incontinence brief. The Nurse turned call light off and brief was not changed. During an interview with Resident 11, on 05/24/2021, at 10:45a.m., Resident 11 stated I waited forever, they finally changed me 3 hours later. 3. A review of Resident 21's Face Sheet indicated Resident 21 was admitted to the facility on [DATE], with diagnoses including muscle weakness and DM. A review of Resident 21's MDS dated [DATE], indicated Resident 21's cognition was intact and required assistance with personal hygiene, toilet use, and bathing. On 05/24/2021 at 2:17 p.m., during an observation, Resident 21's call light was on outside Resident 21's room. At 2:25 p.m., the call light outside Resident 21's room remained on. CNA 2 walked past Resident 21's room. During an interview with Resident 21, on 05/24/2021, at 2:25 p.m., Resident 21 stated she had passed urine and had a bowel (stool) movement in the incontinent brief and wanted to be cleaned up but was waiting for some time for someone to clean and change her. Resident 21 further stated I thought they would be here by now. Someone came in and I asked to be assisted but they said they were not assigned to me and that they would get someone. Resident 21 stated, I just want someone to come change me. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 05/24/2021, at 2:32 p.m., CNA 3 entered Resident 21's room and turned off the call light and told Resident 21 another CNA is assigned to you and I have my residents to clean up. CNA 3 left the room. During an interview with CNA 2, on 05/24/2021 at 2:40 p.m., CNA 2 stated he was busy, and Resident 21 was not assigned him. During an observation on 05/24/2021 at 2:49 p.m., the call light was still on outside Resident 21's room. At 2:54 p.m., CNA 2 entered Resident 21's room, turned off call light and left. At 2:56 p.m., Director of Staff Development/Assistant Infection Preventionist (DSD/AIP) entered Resident 21's room to clean Resident 21. During concurrent interview and record review of the facility's Call Light policy revised 01/01/12, with Director of Nursing (DON) on 5/24/2021 at 1:02PM, the DON stated, promptly means to answer call lights in less than 5 minutes. During an observation on 05/24/2021 at 2:17 p.m., a call light was on outside Resident 21's room. During an observation on 05/24/2021 at 2:25 p.m., a call light was on outside Resident 21's room. CNA 2 walked past Resident 21's room. In a concurrent interview, Resident 21 stated she had passed urine and had a bowel (stool) movement in incontinent brief, wanted to be cleaned up, and had been waiting for some time for someone to help clean and change her. Resident 21 further stated I thought they would be here by now. Someone came in and I asked to be assisted but they said they were not assigned to me and that they would get someone. Resident 21 stated, I just want someone to come change me. During an observation on 05/24/2021 at 2:32 p.m., in Resident 21's room, CNA 3 entered Resident 21's room and turned off Resident 21's call light. CNA 3 told Resident 21 that another CNA is assigned to you and I have my residents to clean up. CNA 3 left the room and called CNA 2. During an interview with CNA 2 on 05/24/2021 at 2:40 p.m., CNA 2 stated he was busy, and that Resident 21 was not assigned him. During an interview with RNA/CNA on 05/24/2021 at 2:42 p.m., RNA/CNA stated, even if it is not our assigned resident, we are supposed to answer the call light. RNA/CNA further stated the CNA who answered the call light was supposed to help the resident if the assigned CNA was busy. RNA/CNA further stated Resident 21 should have been changed because resident could get a sore (wound) from sitting in stool and urine. During an observation on 05/24/2021 at 2:49 p.m., the call light was on outside Resident 21's room. During an interview with the DON on 5/24/2021 at 2:52 p.m., the DON stated CNA 3 should have assisted Resident 21, and that it was not appropriate for CNA 3 to tell Resident 21 that she is not the resident's CNA and not assist resident. The DON further stated Resident 21 could get skin breakdown and UTI because resident was left soiled. DON observed ask CNA 2 to answer call light. During an observation on 05/24/2021 at 2:54 p.m., CNA 2 entered Resident 21's room, turned off call light, and left. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 05/24/2021 at 2:56 p.m., the Director of Staff Development/Assistant Infection Preventionist (DSD/AIP) entered Resident 21's room. The DSD/AIP stated she would clean up resident. 4. A review of Resident 27's Face Sheet indicated Resident 27 was admitted to the facility, on 11/30/2020, with diagnoses including difficulty walking and muscle weakness. A review of Resident 27's MDS, dated [DATE] indicated Resident 27 had no cognitive impairment. A review of the Resident council meeting minutes dated 05/05/2021, at 1:37p.m. indicated, during Resident Council, Resident 27 stated Staff will come when a call light is activated but then will not attend to Resident needs. They just turn off the call light. During an Interview with Certified Nurse Assistant (CNA 1), on 05/24/2021 at 11:00 a.m., CNA 1 stated I cancelled the call light and just left because it was change of shift. I was so busy. CNA 1 further stated But I know this was wrong we need to address the patient's request and change her diaper right away. On 05/24/2021 at 1:02 p.m., during an interview and a concurrent record review with Director of Nursing (DON), of the Call Light policy and procedure revised date on 01/01/2012, the DON stated, promptly means to answer call lights in less than 5 minutes. During an interview with RNA/CNA, on 05/24/2021 at 2:42 p.m., RNA/CNA stated, Even if it is not our assigned resident, we are supposed to answer the call light. RNA/CNA further stated the CNA who answered the call light was supposed to help the resident if the assigned CNA was busy. RNA/CNA further stated Resident 21 should have been changed because resident could get a sore (wound) from sitting in stool and urine. During an interview with RNA/CNA 2, on 05/26/2021 at 8:03 a.m., RNA/CNA 2 stated call lights should be answered immediately, and residents should be the priority. 5. A review of Resident 34's Face Sheet indicated resident was admitted [DATE] with diagnosis of muscle weakness and nicotine dependence. A review of Resident 34's MDS, dated [DATE], indicated Resident 34's cognition was intact. During an interview on 05/25/2021 at 8:59 a.m., Resident 34 stated staff took half an hour to one hour to respond to call light. Resident 34 further stated the call light response delay was worse in the morning and in the afternoon. Resident 34 continued to state that sometimes the staff just shut off the call light without asking me what I want. 6. A review of Resident 318's Face Sheet, indicated the facility admitted Resident 318 on 05/20/2021, with diagnoses including anxiety (a feeling of apprehension and fear, characterized by physical symptoms such as palpitations, sweating, and feelings of stress), and asthma (breathing problem). During an interview with Resident 318 on 05/24/2021 at 9:24 a.m., Resident 318 stated staff don't respond to the call light, I press the call light, but no one comes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 05/24/2021 at 10:40 a.m., the call light was on outside Resident 318's room. During observation on 05/24/2021 at 10:42 a.m., the call light was on outside Resident 318's room. LVN 3 pushed the medication cart by and past Resident 318's room. LVN 3 did not answer the call light. During observation on 05/24/2021 at 10:50 a.m., the call light was on outside Resident 318's room. Resident 318 was observed walk outside the room. A review of the facility's policy and procedures titled Communication Call System with revised date of 01/01/2012, indicated Nursing Staff will answer call bells promptly . In answering the request, Nursing Staff will return to resident with the item or reply promptly. Assistance will be offered before leaving.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40541 Based on observation, interview and record review, the facility failed to provide supervision for eight of 61 sampled residents (Residents 4, 32, 34, 121, 122, 129, 130, and 131 when smoking. The facility was aware Resident 4 used a personal lighter to light a fire when crafting, had crafting tools including (a boxcutter, scissors, and long-nosed gripping hand tool), and did not supervise Resident 4. This deficient practice had the potential for fire related accidents in the facility among residents, staff, and or guests. Findings: 1. A review of the Facesheet (Admission Record), indicated the facility initially admitted Resident 4 on 08/20/2017, and was readmitted on [DATE], with diagnoses including end stage renal disease (ESRD, is the final, permanent stage of chronic kidney disease, where kidney function has declined and can no longer function), diabetes mellitus (high levels of sugar in the blood) with diabetic chronic (long-term) kidney disease, dependence on renal dialysis, disorder of kidney and ureter (tube that carries urine from the kidneys to the bladder), atherosclerotic (narrowing of arteries due to plaque buildup on the artery walls) heart disease of native coronary (relating to the arteries which surround and supply the heart) artery without angina pectoris (chest pain), and hypertensive (pertaining to high blood pressure) chronic kidney disease. 2. A review of the Facesheet, indicated the facility admitted Resident 32 on 05/09/2021, with diagnoses including hypertensive heart disease, diabetes mellitus, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures (uncontrolled electrical activity in the brain, which may produce a physical convulsion), and generalize muscle weakness. 3. A review of the Facesheet, indicated the facility admitted Resident 34 on 09/17/2021, with diagnoses including anoxic (when the body or brain completely loses oxygen supply) brain damage, nicotine dependence, intermittent (stopping and starting over a period of time) asthma (a condition in which a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe), and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures (uncontrolled electrical activity in the brain, which may produce a physical convulsion). 4. A review of the Facesheet, indicated the facility admitted Resident 121 on 05/09/2021, with diagnoses including chronic obstructive pulmonary disease (COPD - a long-term lung disease that blocks airflow and makes it difficult to breathe), hypertensive heart disease, nicotine dependence, and malignant neoplasm (uncontrolled cancer growth that spreads to other parts of the body) of bronchus or lung. 5. A review of the Facesheet, indicated the facility admitted Resident 122 on 05/14/2021, with diagnoses including asthma, COPD, diabetes mellitus with diabetic chronic kidney disease, and seizures. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. A review of the Facesheet, indicated the facility admitted Resident 129 on 05/21/2021, for short term skilled rehabilitation and nursing care. A review of the undated History and Physical, indicated Resident 129 had diagnoses including seizures. 7. A review of the Facesheet, indicated the facility admitted Resident 130 on 05/19/2021, with diagnoses including lateral malleolus (a bony projection with a shape likened to a hammer head, especially each of those on either side of the ankle) fracture of left fibula (the outer and usually smaller of the two bones between the knee and ankle), generalized muscle weakness, and nicotine dependence, cigarettes. 8. A review of the Facesheet, indicated the facility admitted Resident 131 on 05/11/2021, with diagnoses including aphasia (a language disorder that affects a person's ability to communicate), cerebral infarction (stroke), and hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time). During an observation on 05/24/2021 at 11:18 a.m., Resident 4 and 122, were smoking on the patio without supervision. In a concurrent interview, Resident 122 stated staff did not supervise Residents 4 and 122 while smoking on the patio, were able to keep their cigarettes and lighters on their person, had access the patio from their room using the sliding door, and could smoke at any given time without supervision. Resident 121 confirmed Resident 122's statement. Residents 121 and 122 denied awareness of a smoking schedule. During an observation on 05/24/2021, at 11:24 a.m., Residents 4 and 121 were smoking on the patio without supervision. In a concurrent interview, Residents 4 and 121 stated they were able to keep their cigarettes and lighter and access the patio using their room's sliding door to smoke at any given time without supervision. During an observation on 05/24/21, at 12:02 p.m., Resident 4 had a crafted miniature raft like object made of popsicle sticks, different color paint bottles, a metal pipe, needle nose pliers, scissors, and lighter on patio smoking a cigarette without supervision. In a concurrent interview, Resident 4 stated he made crafts using the tools observed. Resident 4 lit the bowl of the metal pipe with his lighter and rounded the corners of a popsicle stick using the [NAME] (a small piece of burning or glowing coal or wood in a dying fire) in the bowl of the metal pipe, stating it was the method he used to round the corners of the crafted raft like object. Resident 4 further stated staff were aware he used the items to make crafts. Resident 4 also stated he did not require supervision when making the crafts or when smoking. During an interview on 05/24/2021, at 1:17 p.m., Resident 130 stated he was always able to keep his cigarettes and lighter with him at all times. During an observation on 05/24/2021, at 4:27 p.m. Residents 4, 32, 34, 121, 122, 129, 130, and 131 sitting and smoking cigarettes on the patio smoking unsupervised. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation with the Director of Staff Development/Infection Preventionist Nurse (DSD/IP) on 05/24/2021 at 4:30 p.m., Residents 4, 32, 34, 121, 122, 129, and 131 sitting and smoking cigarettes on patio unsupervised. Resident 4 was further observed with the previously mentioned crafting tools and a box cutter. Resident 130 was observed with a pack of cigarettes and a lighter on his lap without supervision. In a concurrent interview, the DSD/IP confirmed and stated Resident 4 had crafting materials, including a box cutter, and Resident 4, 32, 34, 121, 122, 129, 130, and 131 smoking without supervision. The DSD/IP further stated Residents 4, 32, 34, 121, 122, 129, 130, and 131, should not be smoking, sharing cigarettes and lighters, or using crafting materials without supervision for safety. During an interview on 05/27/2021 at 12:07 p.m., the Assistant Administrator (AADM) confirmed and stated that facility staff were not supervising the residents who smoked on a consistent basis. A review of the facility's untitled and undated smoking schedule indicated smoking hours of 8:30 a.m. to 9:00 p.m., included 8:30 a.m. to 9:00 a.m., 10:00 a.m. to 10:30 a.m., 1:00 p.m. to 1:30 p.m., 3:30 p.m. to 4:00 p.m. , 6:00 p.m. to 6:30 p.m., and 8:30 p.m. to 9:00 p.m. The smoking schedule indicated all smokers will be supervised and be assisted by a staff in the patio at all times. A review of the facility's policy and procedures titled Smoking by Residents revised on 01/2017, indicated to provide a safe environment for residents, staff, and visitors. It is the policy of this facility to accommodate residents who desire to smoke by taking reasonable precautions, providing a safe environment for them, and protecting the non-smoking residents. Smoking whether it is traditional tobacco . smoked in cigarettes, pipes . are governed by this policy. Smoking by residents is allowed outside of the facility in designated, marked smoking areas . The facility may develop a smoking scheduled to ensure a safe environment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40541 Based on observation, interview, and record review, the facility failed to monitor and identify signs of urinary tract infection (UTI) and report to the physician for one of two residents (Resident 67). Resident 67, who had an indwelling urinary catheter (a soft hollow tube which is passed into the bladder to drain urine, for persons who cannot empty their bladder in the usual way), the urine was cloudy (not clear) urine and with sediments (substances present in urine) and the abnormal urine was not reported to the physician as a possible UTI. This deficient practice resulted in delayed diagnosis and treatment for a possible UTI Findings: A review of Resident 67's Face Sheet (Admission Record), indicated the facility admitted Resident 67 on 5/5/2021, with diagnoses including paraplegia (complete or partial loss of movement or feeling in the lower half of the body), retention of urine, and personal history of urinary tract infections. A review of the Resident 67's Minimum Data Set (MDS, a standardized resident assessment and care-screening tool) dated 5/12/2021, indicated Resident 67's cognition (ability to understand, learn, remember, and make decisions of daily living) was intact. The MDS indicated resident 67 used a manual wheelchair for mobility, required limited assistance with bed mobility, eating and personal hygiene, and was totally dependent on staff for transfers, dressing, toilet use, and bathing. During an observation on 5/24/2021 at 10:35 a.m., Resident 67's catheter tubing had cloudy urine with sediments. During an observation of Resident 67's catheter and concurrent interview on 5/24/2021, at 5:40 p.m., Director of Nursing (DON) stated Resident 67's catheter tubing had cloudy urine with sediments. DON further stated Resident 67 should be monitored for signs and symptoms of UTI, and the resident's physician should be informed of the change in condition. During an interview and concurrent review of Resident 67's clinical record on 05/26/2021, at 11:49 a.m., Assistant Director of Nursing (ADON) stated there was no record of an assessment or change of condition for cloudy urine with sediments for Resident 67 on 5/24/2021. ADON further stated an assessment or change of condition should have been conducted, physician should have been notified, and a change of condition should have been documented for timely treatment and monitoring. During an observation and concurrent interview with Licensed Vocational Nurse/Minimum Data Set Nurse 3 (MDS/LVN 3) on 5/26/2021, at 12:15 p.m., LVN 3 stated Resident 67's catheter tubing had cloudy urine with sediments. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent review with LVN 8 on 5/26/2021, at 12:44 p.m., LVN 8 stated Resident 67's care plan indicated to call physician for urinary status changes. LVN 8 further stated there was no record of change of condition or a call was made to Resident 67's physician. LVN 8 stated the licensed nurses should have notified the attending physician of Resident 67's change of condition due to cloudy urine with sediments to ensure timely monitoring and treatment. A review of the facility's policy and procedures titled Change of Condition Notification, revised date 4/1/2017, indicated to ensure . physicians are informed of changes in the resident's condition in a timely manner. The facility will promptly inform the resident's attending physician . when the resident endures a significant change in their condition caused by, but not limited to . a significant change in the resident's physical . status. change in condition related to attending physician notification is defined as when the attending physician must be notified when any sudden and marked adverse change in the resident's condition which is manifested by signs and symptoms different than usual denote a new problem . in status and require a medical assessment, coordination and consultation with the attending physician and a change in treatment plan. It is the responsibility of the person who observes the change to report the change to the to the licensed nurse. The licensed nurse will assess the change of condition and determine what nursing interventions are appropriate. Before notifying the attending physician, the license nurse must observe and asses the overall condition utilizing a physical assessment and chart review. Notification to the attending physician will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required. A licensed nurse will notify the resident's attending physician . when there is a significant change in the resident's physical . status .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40541 Based on observation, interview, and record review, the facility failed to: 1. Arrange for a reliable and timely transportation services to a hemodialysis (also known as dialysis - a treatment that filters and purifies the blood using a machine. Dialysis allows patients with kidney failure a chance to live productive lives) treatment center 2. Notify the physician of missed dialysis appointments 3. Maintain accurate SNF (Skilled Nursing Facility) pre (before) dialysis assessment forms 4. Arrange for dialysis treatment with one dialysis service center for one of 61 sampled residents (Resident 4). These deficient practices resulted in Resident 4 missing several (approximately six) dialysis treatments, placed Resident 4 at risk of health complications related to missed and or duplicate dialysis treatment, and Resident 4 to not attain or maintain the highest practical level of physical, mental and psychosocial well-being. Findings: A review of the Facesheet (Admission Record) indicated the facility initially admitted Resident 4 on 08/20/2017, and was readmitted on [DATE], with diagnoses including end stage renal (kidney) disease, diabetes mellitus (high levels of sugar in the blood) with diabetic chronic (long-term) kidney disease, dependence on renal dialysis, disorder of kidney and ureter (tube that carries urine from the kidneys to the bladder), hypertensive (pertaining to high blood pressure) chronic kidney disease. A review of the Resident 4's Minimum Data Set (MDS, a standardized resident assessment and care-screening tool) dated 05/11/2021, indicated Resident 4's cognition was intact, required supervision for bed mobility, transfer, walking, eating, toilet use, personal hygiene, and limited assistance with dressing, and extensive assistance with bathing. A review of the Facesheet indicated the facility admitted Resident 126 (Resident 4's roommate) on 05/18/2021, with diagnoses including hyperlipidemia (high levels of fats (lipids) in the blood), difficulty in walking, duodenitis (inflammation occurring in the duodenum, the beginning of the small intestine) without bleeding, pain in knee. A review of the Resident 126's MDS dated [DATE], indicated Resident 126's cognition was intact, was independent for bed mobility and eating, required supervision for transfer, walking, dressing, toilet use, personal hygiene, and bathing. During an interview on 05/24/2021 at 11:53 a.m., Resident 126, stated Resident 4 missed dialysis appointment on 05/24/2021. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/24/21 at 12 p.m., Resident 4 stated he was not picked up for dialysis appointment on 05/24/2021. Resident 4 further stated he had missed other dialysis appointments because transportation failed to pick him up. During an interview and concurrent review of the Resident 4's clinical record with Licensed Vocational Nurse 8 (LVN 8) on 05/26/2021, at 1:15 p.m., LVN 8 stated Resident 4 missed dialysis appointment because transportation did not pick the resident on 05/24/2021. LVN 8 further stated she did not notify the Resident'4 physician of missed dialysis appointment, nor and call the dialysis center to reschedule a new dialysis appointment. During an interview and concurrent review of the Resident 4's clinical record on 05/26/2021, at 1:24 p.m., LVN 8 stated she was unaware of a system in place for back up transportation to dialysis appointments during the night shift to ensure dialysis residents arrive timely and did not miss dialysis appointments. LVN 8 further stated the facility should have a system in place for missed transportation, and ensure residents arrived for dialysis treatment appointments in a timely manner to prevent any health complications. During an interview and concurrent review with Social Services Director (SSD) of Resident 4's clinical record on 05/27/2021 at 12:21 p.m., the SSD stated Resident 4 missed dialysis treatment appointment on 5/24/2021. SSD further stated Resident 4 has missed other scheduled dialysis appointments because scheduled transportation did not pick up Resident 4. During an interview and record review with Licensed Vocational Nurse/Minimum Data Set Nurse (LVN/MDS) of Resident 4's clinical record on 06/01/2021, at 10:54 a.m., the LVN/MDS stated, physician order for dialysis found on titled summary report form indicated dialysis order on 02/24/2021, and for hemodialysis three times a week every Monday, Wednesday, and Friday at 4:00 a.m. The order further indicated the dialysis center address, transportation company name and 24 hours a day, 7 (seven) days a week contact information, and nephrologist's (a doctor who specializes in kidney disease) name and contact phone number. LVN/MDS further stated the contact information for the transportation company, nephrologist, and dialysis center were on Resident's 4 order summary report. During an interview and record with LVN/MDS review of Resident 4's clinical record on 06/01/2021 at 11:10 a.m., the LVN/MDS stated the facility's document titled skilled nursing facility (SNF) pre (before) dialysis assessment form, dated 05/12/2021 indicated Resident 4 left the facility for his dialysis appointment at 12:20 p.m. LVN/MDS further stated there was no recorded reason why Resident 4 left the facility for dialysis on 05/12/2021 at 12:20 p.m. instead of ordered time at 4:00 a.m. as per dialysis appointment scheduled. LVN/MDS stated accurate documentation should have been done to ensure coordination of care. During an interview and record review of Resident 4's clinical record on 06/01/2021, at 11:21 a.m., LVN/MDS stated nursing note dated 05/24/2021 timed 11:59 p.m., indicated the Assistant Director of Nursing (ADON), wrote an order for extra dialysis appointment for 05/25/2021 at 4:00 a.m., for Resident 4. The LVN/MDS stated, nursing also informs the Administrator to ensure back up transportation is provided for timely dialysis appointment when a resident misses dialysis treatment appointment. The LVN/MDS further stated the contact information was included on the physician order, and there was no documented order for dialysis after 05/24/2021. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review with LVN/MDS of Resident 4's clinical record on 06/01/2021, at 11:26 a.m., the LVN/MDS stated that on 05/05/2021, 05/07/2021, 05/10/2021, 05/17/2021, 05/19/2021, and 05/28/2021 SNF pre dialysis assessment forms were missing from Resident 4's clinical record. LVN/MDS further stated the documents should be in Resident 4's clinical record for accurate coordination of care. During an interview and record review with the Director of Nursing (DON) of Resident 4's clinical record on 06/01/2021, at 3:15 p.m., the DON stated the night nurse should have contacted the nephrologist, the dialysis center and schedule a new chair time and arrange for transportation in a timely manner to prevent any health complications. The DON further stated two SNF pre-dialysis forms dated 05/12/2021, indicated time left was 4:00 a.m. and 12:20 p.m. The DON stated documentation should reflect Resident's accurate information. The DON confirmed and stated no record of SNF pre-dialysis forms were found in Resident 4's clinical record for the dates 5/5/2021, 05/07/2021, 05/10/2021, 05/17/2021, 05/19/2021, and 05/28/2021. During an interview and record review with the ADON of Resident 4's clinical record on 06/02/2021 at 10:09 a.m., the ADON stated no documentation for dialysis for 05/5/2021, 05/7/2021, and 05/11/2021 were in Resident 4's clinical record. The ADON further stated Resident 4 missed dialysis on 05/10/2021 and Resident 4's clinical record, had two SNF pre-dialysis forms for 05/12/2021, and did not know the reason why there were two forms dated 05/12/2021with the different times that indicated Resident 4 left the facility for dialysis at 4:00 a.m. and 12:20 p.m. During an interview and record review with the ADON of Resident 4's clinical record on 06/02/2021 at10:30 a.m., the ADON stated there were no records for Resident 4's dialysis appointments from 05/12/2021 to 05/18/2021. The ADON stated no documentation regarding dialysis on 05/19/2021 for Resident 4 in clinical record. The ADON further stated Resident 4 missed dialysis on 05/24/2021, no documentation for change of condition, or follow-up call to the physician, Administrator or to the dialysis center for a new chair time by the attending nurse when Resident 4 was not picked up for dialysis appointment on 05/24/2021. During a concurrent interview and record review with the ADON of Resident 4's clinical record on 06/02/2021 at 10:31 a.m., the ADON stated there was no dialysis record for Resident 4 on 05/28/2021. The ADON further stated there should be records on file for Resident 4's dialysis for dates 05/05/20, 05/07/2021, 05/10/21, 05/17/2021, 05/19/2021, and 05/28/2021. The ADON stated if the information is not documented in Resident 4's clinical record, then the services and care were not provided. During an interview and record review with the ADON of Resident 4's clinical record on 06/02/2021 at 1:30 p.m., the ADON stated Resident 4 receives dialysis at two locations. The ADON further stated Resident 4 had four dialysis make-up days on 05/06/2021, 05/11/2021, 05/18/2021, and 05/25/2021 at the second location to make-up for 05/05/2021, 05/10/2021, 5/17/2021, and 05/25/2021. During an interview on 06/02/2021 at 3:00 p.m., DON stated no record of pre/post dialysis assessments for Resident 4 dialysis treatment appointments on 05/06/2021, 05/07/2021, 05/11/2021, 05/18/2021, 05/19/2021, and 05/28/2021. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures titled Dialysis Care revised on 10/01/2018, indicated to provide dialysis care for residents in renal failure and those residents who require ongoing dialysis treatment. The facility will arrange for dialysis care as ordered by the attending physician.The nursing staff will communicate the following information in writing to the dialysis staff; the resident's current vital signs; weight; and any changes of conditions specific to the resident with each treatment . Nursing staff will keep the attending physician, the resident and the residents family informed of any change in conditions. All documentation concerning dialysis services and care of the dialysis resident will maintained in the resident's medical record. Documentation may include . pre/post dialysis assessment . The nursing staff will sed a dialysis communication form to the dialysis center every time a resident is scheduled for off-site dialysis. The provider's dialysis nurse will be resopnsie.be for documentation of dialysis treatment. Documentation will be maintained in the residents' medical record.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure two of two licensed staff nurses (Licensed Vocational Nurse 6 [LVN 6] and LVN 3) were evaluated for competence with medication pass and assessment skills. This deficient practice resulted to significant medication error. Cross reference F755 Findings: 1. During a medication pass observation on 5/25/2021 at 9:38 a.m., on [NAME] Nursing Station, LVN 6 failed to verify Resident 11's identity prior to administering the morning medications. During a medication pass observation on 5/25/2021 at 9:58 a.m., on [NAME] Nursing Station, LVN 6 failed to verify Resident 269's identity prior to offering the morning medications. During an interview on 5/25/2021 at 10:04 a.m., LVN 6 stated for Residents 11 and 269, I did not look at the residents (Residents 11 and 269) armbands or ask the residents to state their names. I did not look at them because I know the residents (Residents 11 and 269) by face because I have worked with them for some time. For new admission I will verify identity by looking at the resident identification (ID) on the armband, asking the resident to state their name or have another staff verify the resident's identity. LVN 6 further stated I should have verified the residents' (Residents 11 and 269) identity before administering medication to (Resident 11) or offering to administer the medications to (Resident 269). During a medication pass observation on 5/25/2021 at 10:25 a.m., on East Nursing Station, LVN 3 entered the shared residents' room and stated, Which resident is asking for pain medication? The resident (Resident 10) next to the window raised her hand. LVN 3 called Resident 10 by her roommate's name (Resident 13). LVN 3 did not verify Resident 10's identity, ask the resident to state her name, or ask what her pain level was. LVN 3 went back to the medication cart to look for pain medication for Resident 13. Resident 13 whose bed was next to the door observed sleeping in her bed. LVN 3 stated the incorrect resident's (Resident 13) name again stating she (Resident 13, the incorrect resident) has an order for Morphine (medication for pain) for pain. LVN 3 was unable to locate the pain medication in the [NAME] MedCart or the refrigerator in the medication storage room. During an observation on 5/25/2021 at 11:27 a.m., LVN 3 entered Resident 13's room and awaken her to administer the morning medications. LVN 3 failed to use any identifiers to verify the resident's identity. LVN 3 did not look for an ID armband ask the resident to state her name, and there was no resident picture observed on Resident 13's MAR. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN 3, on 5/25/2021 at 11:30 a.m., LVN 3 stated, I called Resident 10 by another resident's name (Resident 13). I did not ask the resident (Resident 10 or Resident 13) to state their names. I thought Resident 13 was Resident 10. I did not know which resident was in which bed. I should have asked another staff that knew the resident to identify the resident when the resident is not wearing an identifying armband or have a picture on file. A review of the facility's policy and procedures (P&P) titled, Medication Administration, revision dated 1/2012, indicated, No medication will be used for any patient other than the patient for whom it was prescribed .The Licensed Nurse will verify the resident's identity before administering the medication .Nursing Staff will keep in mind the seven rights of medication when administering medication. The seven rights of medication are. The right resident. The right time . 2. During a concurrent observation and interview on 5/25/2021, at 9:38 a.m., at the [NAME] Nursing Station Medication Cart (West MedCart), LVN 6 stated he prepared all but one of Resident 11's morning medication that totalled seven and it should have been eight medications. LVN 6 stated Resident 11 was supposed to receive an antibiotic medication Levofloxacin (used to treat urinary tract infection) which was unavailable. LVN 6 stated the levofloxacin (medications to treat infections) was unavailable and not administered to Resident 11. LVN 6 did not document the antibiotic was not given at the back of the MAR sheet. LVN 6 did not give Resident 11 Celebrex (for pain) and Pro-Stat liquid (protein supplement). During a concurrent observation and interview, on 5/25/2021, at 10:04 a.m., LVN 6 stated Resident 269 was asking for Tylenol, but does not have an order for Tylenol in the MAR. LVN 6 was not observed assessing Resident 269 for pain or asking for resident's pain level. During concurrent interview and record review on 5/26/2021, at 2:29 p.m., Resident 10's MAR, dated May 2021 was reviewed and the Pain Assessment Flow Sheet had missing documentation for Resident 10's Norco administration on 5/25/2021 at 11:00 a.m. Yesterday (5/25/2021) the resident (Resident 10) was complaining about pain that is why I gave her the Norco. LVN 3 stated he forgot to document on the Pain Assessment Flowsheet, and he should have documented on the Pain Assessment Flow Sheet as well as on the back of the MAR for the administration of Norco to Resident 10 on 5/25/2021. The back of Resident 10's MAR for Norco was blank, missing documentation to indicate Resident 10 was assessed and reassessed to determine the effectiveness of the pain medication of Norco, after administration. During concurrent interview and record review on 5/26/2021, at 2:41 p.m., with LVN 3, Resident 13's MAR, dated May 2021 was reviewed. The MAR indicated, on 5/25/2021, for the 9 a.m. administration time, there were no licensed staff initials in the boxes for Resident 13's Simbrinza (Brinzolamide 1 % [percentage]-Brimonidine 0.2%, medication to treat primary open-angle glaucoma [[NAME]] a leading cause of blindness) Suspension 1-0.2%, eye drop, to demonstrate the medication was administered. LVN 3 stated, The eye drop was not offered to the resident (Resident 13). I should have documented an attempt to offer the eye drop to the resident. I did not notify the physician or another nurse that the medication was not administered. LVN 3's initial was observed on the MAR to demonstrate the medication was administered to Resident 13 on 5/25/2021, for the 9 a.m. administration time. LVN 3 stated Resident 13 refused medications on 5/25/2021 for the 9 a.m. administration time and he should have circled his initial to indicate the resident refused the medications and the documentation of the medication administration was incorrect. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Staff Development (DSD), on 5/26/2021 at 8:28 a.m., the DSD stated registry staffs are to be evaluated for competence with medication pass and assessment skills. The DSD stated there was no time to go over competency check list because there was not enough time to check those details with registry. The DSD further stated registry staff are for emergency for licensed staff. The DSD further stated the registry staff do not stay that long therefore there are times she was unable to verify if they are competent. The DSD further stated registry staffs are not as thorough as regular staffs. A review of the facility's policy and procedure titled, Staff Competency or Skills Checks, revised on 8/22/2019, indicated, The purpose of completing competency evaluations or skills checks is to determine knowledge and/or performance of assigned responsibilities based on standard of practice, policy and procedure and regulatory requirement.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview, and record review, the facility failed to ensure pharmaceutical services were provided accurately and safely for 10 of 11 sampled residents (Residents 10, 11, 13, 15, 23, 31, 45, 56, 61, and 269). The facility failed to: 1. Verify the residents' identity prior to administering medications to Residents 10, 11, 13 and 269 2. Ensure residents' medications ordered by the physician were available in the medication cart for administration to Residents 10, 11, 13, and 269, and the physician was notified timely if the medication was unavailable or the resident refused to take it. 3. Ensure medication administration for Residents 15, 23, 31, 45, 56, and 61 was documented per facility's policy on medication administration when medication was administered more than one hour before or after the scheduled medication administration time on the Medication Administration Record (MAR) and the nursing progress notes. The facility did not notify promptly the attending physician of Residents 15, 23, 31, 45, 56, and 61 for late or missed medication administration and did not document the notification in the residents' medical records. 4. Ensure Residents 15, 23, 31, 45, 56, and 61 received their medications as prescribed by the physician. There was no documentation (licensed nurses initials) on the MAR the medications were administered, the initials of the licensed nursing staff on the MAR. 5. Ensure medications removed from the emergency medication kit (E-kit) stored in the Medication Cart (MedCart) of the Yellow Zone (an area designated for resident with Coronavirus Disease 2019 [COVID-19 a highly contagious viral infection that affects the respiratory system] status not determined yet waiting for laboratory results) were accurately accounted for and were documented including the name of the resident, name of the medication removed, and date of the medication removal from the E-kit for resident administration. The licensed nurses did not document the removal of Furosemide (water pill) from the E-kit, the date of the medication removal and the name of the resident. These deficient practices increased the risk for adverse effects due to the residents not receiving medications necessary to treat and/or control potentially life-threatening medical conditions, including, high blood pressure for Residents 10, 11, 15, 23, 31, 45, 61, and 269; heart disease including atrial fibrillation (an irregular heartbeat) or heart failure for Residents 10 and 269; diabetes (A chronic condition that affects the way the body processes blood sugar [glucose]) for Residents 10, 31, and 15; prevention of blood clots including pulmonary embolism (a blood clot that travels to the lungs) for Residents 23 and 269; sleep disorders for Residents 11 and 23; and pain for Residents 11, 45, 61, and 269; thyroid deficiency (a condition in which the thyroid gland does not produce enough thyroid hormone) for Residents 10, 13, 15, 45, and 56; dementia (is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) for Residents 13 and 61; and urinary tract infection prevention for Residents 10, 11, and 13. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	These deficient practices could result in Residents 10,11, 13, 15, 23, 31, 45, 56, 61, and 269 not maintaining therapeutic range levels (the amount of drug levels in the blood in which a drug has the desired effects upon the body) for medications including but not limited to digoxin (medication used to treat heart failure) for Resident 10, and had the potential to result in residents experiencing an increased in anxiety, depression, unnecessary pain, shortness of breath, uncontrolled blood pressure and blood sugar, heart attack, stroke or death. On 5/26/2021, at 5:57 p.m., the Director of Nurses (DON), Assistant Director of Nursing (ADON), and the Administrator (ADM) were verbally notified of an Immediate Jeopardy (IJ: a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) situation. The IJ situation was declared due to facility not identifying residents prior to medication administration, not administering resident medications as ordered by the physician for, high blood pressure, heart disease, heart failure, diabetes, blood clots, thyroid deficiency, dementia, pain, anxiety, depression, and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). The facility failed to provide documentation to verify residents' physicians were notified prior to late medication administration and timely for refused medication administrations or concerns related to missing initials on the MAR, medication error over 5%, medication not given within time frame, no documentation supporting held medication, medication signed in MAR but observed not administered, incomplete documentation, instructions of medication administration not followed, and no pain assessment. On 5/28/2021 at 2:20 p.m., the facility provided a complete POA, which was accepted after an onsite validation through observations, interviews, and record reviews. The IJ was lifted in the presence of DON and ADM. The POA included the following: 1. Assessed the 10 residents affected for any adverse effects related to the missed or late medication administration. All medications administered late were documented and physicians were notified. 2. Residents involved assessed for pain and pain assessment documented in the resident's medical record. 3. DON and Regional Nurse Consultant (RNC), and Pharmacy Nurse Consultants (PNC), provided in-service to licensed nurses regarding facility's policy and procedures on medication administration followed by medication administration competency validation. DON and Director of Staff Development (DSD) provided skilled competency validation, observation, and return demonstration for medication administration for current licensed nursing staff. 4. DON, ADON, and PNC reviewed the remaining 72 residents for timely medication administration. 5. ADM and Assistant Administrator (AADM) conducted rounds on all current residents with a facility census of 82 for identification bands (bracelets). Residents that refused to wear bands, photos were taken and placed in the MAR as mean of identification. 6. Pharmacy Consultant/Licensed Nurse Designee will continue to conduct Medication Pass Observations with return demonstration for Licensed Nursing staff. Findings: (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1a. During a medication pass observation on 5/25/2021 at 9:38 a.m., on [NAME] Nursing Station with Licensed Vocational Nurse (LVN 6), LVN 6 prepared and administered morning medications for Resident 11. LVN 6 failed to verify Resident 11's identity prior to administering the morning medications. 1b. During a medication pass observation on 5/25/2021 at 9:58 a.m., on [NAME] Nursing Station with LVN 6, LVN 6 prepared morning medication and offered the medications to Resident 269. LVN 6 failed to verify Resident 269's identity prior to offering the morning medications. Resident 269 requested Tylenol for a headache and did not take the morning medications when she did not see Tylenol among the medications offered. During an interview on 5/25/2021 at 10:04 a.m., with LVN 6, LVN 6 stated for Residents 11 and 269, I did not look at the residents (Residents 11 and 269) armbands or ask the residents to state their names. I did not look at them because I know the residents (Residents 11 and 269) by face because I have worked with them for some time. For new admission I will verify identity by looking at the resident identification (ID) on the armband, asking the resident to state their name or have another staff verify the resident's identity. LVN 6 further stated I should have verified the residents' (Residents 11 and 269) identity before administering medication to (Resident 11) or offering to administer the medications to (Resident 269). LVN 6 further stated had to administer medications to 37 residents. 1c. During a medication pass observation on 5/25/2021 at 10:25 a.m., on East Nursing Station with LVN 3, LVN 3 entered the shared residents' room and stated, Which resident is asking for pain medication? The resident (Resident 10) next to the window raised her hand. LVN 3 called Resident 10 by her roommate's name (Resident 13). LVN 3 did not verify Resident 10's identity, ask the resident to state her name, or ask what her pain level was. LVN 3 went back to the medication cart to look for pain medication for Resident 13. Resident 13 whose bed was next to the door observed sleeping in her bed. LVN 3 stated the incorrect resident's (Resident 13) name again stating she (Resident 13, the incorrect resident) has an order for Morphine (medication for pain) for pain. LVN 3 was unable to locate the pain medication in the [NAME] MedCart or the refrigerator in the medication storage room. During an interview with LVN 3 and Director of Staff Development/ Infection Preventionist (DSD/IP), on 5/25/2021 at 10:50 a.m., LVN 3 asked the DSD/IP to assist him in looking for the pain medication for the incorrect resident (Resident 13). DSD/IP and LVN 3 were both unable to locate the pain medication Morphine. DSD/IP realized LVN 3 was reviewing the incorrect resident's clinical record and stated Resident 10's bed was close to the window and Resident 13's bed was next to the door. DSD/IP found Resident 10 had an order for the controlled pain medication Norco and not an order for Morphine. During an interview with the DSD/IP, on 5/25/2021 at 10:55 a.m., the DSD/IP stated, I think he (LVN 3) got confused with the beds. The A bed is listed first and then the B, middle bed, and C, the bed next to the window. 1d. During a medication pass observation on 5/25/2021 at 11:20 a.m., on East Nursing Station with LVN 3, LVN 3 prepared morning medications for Resident 13. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Post Acute Care	12121 Santa Monica Boulevard Los Angeles, CA 90025

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 5/25/2021 at 11:27 a.m., LVN 3 entered Resident 13's room and awaken her to administer the morning medications. LVN 3 failed to use any identifiers to verify the resident's identity. LVN 3 did not look for an ID armband ask the resident to state her name, and there was no resident picture observed on Resident 13's MAR. During an interview with LVN 3, on 5/25/2021 at 11:30 a.m., LVN 3 stated, I called Resident 10 by another resident's name (Resident 13). I did not ask the resident (Resident 10 or Resident 13) to state their names. I thought Resident 13 was Resident 10. I did not know which resident was in which bed. I should have asked another staff that knew the resident to identify the resident when the resident is not wearing an identifying armband or have a picture on file. LVN 3 stated he was still passing medication that had a morning administration time of 9 a.m. and had five more residents' rooms to go to complete the morning medication pass. A review of the facility's policy and procedures (P&P) titled, Medication Administration, revision dated 1/2012, indicated, No medication will be used for any patient other than the patient for whom it was prescribed .The Licensed Nurse will verify the resident's identity before administering the medication .Nursing Staff will keep in mind the seven rights of medication when administering medication. The seven rights of medication are. The right resident. The right time . 2a. During a concurrent observation and interview on 5/25/2021, at 9:38 a.m., with LVN 6, of the [NAME] Nursing Station Medication Cart (West MedCart), LVN 6 prepared and administered morning medications to Resident 11. LVN 6 stated he prepared all but one of Resident 11 morning medication that total seven and it should have been eight medications. LVN 6 stated Resident 11 was supposed to receive an antibiotic medication Levofloxacin (used to treat urinary tract infection) which was unavailable. LVN 6 stated the levofloxacin (medications to treat infections) was unavailable and not administered to Resident 11. LVN 6 did not document the antibiotic was not given at the back of the MAR sheet. LVN 6 did not give Resident 11 Celebrex (for paint) and Pro-Stat liquid (protein supplement). A review of Resident 11's Admission Record indicated Resident 11 was readmitted to the facility on [DATE] with diagnoses including hypertension, history of urinary tract infections, insomnia (difficulty falling or staying asleep), and depression. A review of Resident 11's History and Physical (H&P) Examination (the initial clinical evaluation and examination of the resident) dated 4/25/2021 indicated Resident 11 had the capacity to understand and make decisions. A review of Resident 11's clinical records were inconsistent to determine if the resident had an active order for the antibiotic levofloxacin. A review of Resident 11's Physician's Order indicated to give levofloxacin 500 milligrams (mg), one tablet by mouth one time a day for UTI (urinary tract infection) with an order date of 4/24/2021. A review of Resident 11's Care Plan indicated under Focus: The resident is on antibiotic therapy for UTI, date created 5/26/2021 and a target date of 4/14/2021, a date in the past. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a continued observation and interview with LVN 6, on 5/25/2021, at 10:04 a.m., LVN 6 stated Resident 269 was asking for Tylenol, but does not have an order for Tylenol in the MAR. LVN 6 was not observed assessing Resident 269 for pain or asking for resident's pain level. LVN 6 stated Resident 269 refused all the morning medications because the Tylenol she requested was not added. LVN 6 stated Resident 269 always refuse medications and he will change the MAR to resident refused and will waste the seven prepared medications. LVN 6 stated he would circle his initial, which means the resident did not take the medications. LVN 6 was observed placing Resident 269's medications in a sharps container for disposal that was in the bottom of his medication cart. LVN 6 stated Resident 269's blood pressure was high (160/89) and acknowledged the medications disposed included blood pressure medications and blood thinners to prevent clots. LVN 6 stated Resident 269 physician was not notified resident frequently refuses morning medications and that he would call the doctor later today to regarding the Resident 269's request for Tylenol for pain. LVN 6 further stated Resident 269's was supposed to receive one more morning medication, but the medication was unavailable in the [NAME] MedCart. LVN 6 showed an empty bubble pack (a medication pack with each tablet or capsule individually sealed and labeled with date) labeled for Resident 269 that indicated the order was for Divalproex Sodium 125 mg capsule. During a review of the facility's policies and procedures titled, Medication - Verification,' revision date 1/2012, indicated, Medications are administered safely and appropriately as ordered. During a review of the facility's policies and procedures titled, Medication Administration, revision date 1/2012, indicated, If resident is refusing to take medication, time of refusal must be circled in the Medication Administration Record (MAR) and initialed by the Licensed Nurse who is passing meds (medications) and documentation will be entered on the back of the MAR stating the reason for the refusal. The Licensed Nurse will attempt to give the medications several times, but if resident continues to refuse after one hour, the refused medications will be destroyed. Licensed Nurse will notify M.D. (physician) and document in the medical record. 2c. A review of Resident 10's Admission Record indicated Resident 10 was readmitted on [DATE] with diagnoses including heart failure, hypertension, atrial fibrillation, diabetes, depression, muscle weakness, and dysphagia (difficulty swallowing). A review of Resident 10's H&P, dated 5/19/2021, indicated, resident has the capacity to understand and make decisions. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During concurrent interview and record review on 5/26/2021, at 2:29 p.m., with LVN 3, Resident 10's MAR, dated May 2021 was reviewed. The MAR indicated, on 5/25/2021, for the 9 a.m. administration time, there were no licensed staff initials in the boxes for Resident 10's Basaglar KwikPen (insulin pen to control blood sugar) Solution Pen-injector 100 units per milliliter (units/ml), Pro-Stat Sugar Free Liquid (supplement), Gabapentin (medication to treat nerve pain) tablet 600 mg, to demonstrate the medications were administered and Pain Assessment Flow Sheet was missing documentation for Resident 10's Norco administration on 5/25/2021 at 11:00 a.m. LVN 3 stated, there was no documentation on the MAR for 5/2021 indicating Resident 10 received Basaglar KwikPen, Gabapentin and the Pro-stat was unavailable for administration on 5/25/2021 and again on 5/26/2021. LVN 3 stated, I did not document anywhere the medicines were not given. Gabapentin was not given yesterday (5/25/2021). The medicine was not in the MedCart. If I did not sign the MAR, the medicine was not given. I did not document, notify the physician or let anyone know the resident (Resident 10) did not receive the medications (Gabapentin, Basaglar KwikPen, or Pro-stat). Gabapentin is for pain. Yesterday (5/25/2021) the resident (Resident 10) was complaining about pain that is why I gave her the Norco. The Gabapentin may have helped reduce her pain. LVN 3 stated he forgot to document on the Pain Assessment Flowsheet, and he should have documented on the Pain Assessment Flow Sheet as well as on the back of the MAR for the administration of Norco to Resident 10 on 5/25/2021. The back of Resident 10's MAR for Norco was blank, missing documentation to indicate Resident 10 was assessed and reassessed to determine the effectiveness of the pain medication of Norco, after administration. A review of the facility's P&P titled, Medication Ordering and Receiving - Ordering and Receiving Medications from the Dispensing Pharmacy, effective date 2/2015, indicated, Reorder medications three days in advance of need to assure an adequate supply is on hand. 2d. During concurrent interview and record review on 5/26/2021, at 2:41 p.m., with LVN 3, Resident 13's MAR, dated May 2021 was reviewed. The MAR indicated, on 5/25/2021, for the 9 a.m. administration time, there were no licensed staff initials in the boxes for Resident 13's Simbrinza (Brinzolamide 1 % [percentage]-Brimonidine 0.2%, medication to treat primary open-angle glaucoma [[NAME]] a leading cause of blindness) Suspension 1-0.2%, eye drop, to demonstrate the medication was administered. LVN 3 stated, The eye drop was not offered to the resident (Resident 13). I should have documented an attempt to offer the eye drop to the resident. I did not notify the physician or another nurse that the medication was not administered. LVN 3's initial was observed on the MAR to demonstrate the medication was administered to Resident 13 on 5/25/2021, for the 9 a.m. administration time. LVN 3 stated Resident 13 refused medications on 5/25/2021 for the 9 a.m. administration time and he should have circled his initial to indicate the resident refused the medications and the documentation of the medication administration was incorrect. LVN 3 stated the following medications was offered, and Resident 13 refused on 5/25/2021 for the 9 a.m.: i. Cranberry Supplement 450 mg, one tablet (to assist with prevention of UTI) ii. ClearLax (Miralax - a laxative to treat constipation) one capful 17 grams (gm) in 4 ounces (oz) water iii Multiple Vitamins (supplement), one tablet iv. Vitamin D 25 (supplement) micrograms (mcg) one tablet v. Docusate Sodium (stool softener) 100 mg, one capsule (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During concurrent interview and record review on 5/26/2021, at 4:07 p.m., with Medical Records Supervisor (MRS), Nursing Progress Notes were reviewed for Residents 10, 11, 13, and 269 for 5/2021. MRS stated there was no documentation the physician was notified of the refused medications for Resident 269 and Resident 13. MRS stated there was no documentation to clarify the discrepancy on Resident 11's antibiotic medication levofloxacin, the omitted morning medications for Residents 10 and 13, or the request for Tylenol pain medication for Resident 269 on 5/25/2021 during the 9 a.m. morning medication pass. A review of the facility's P&P titled, Medication Ordering and Receiving: Ordering and Receiving Medications from the Dispensing Pharmacy, effective date 2/2015, indicated, Reorder medication three days in advance of need to ensure adequate supply is on hand. A review of the facility's P&P titled, Medication Administration, revision date 1/2012, indicated, Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. The Licensed Nurse will chart the drug, time administered and initial his/her name with each medication administered and sign full name and title on each page of the Medication Administration Record (MAR). Whenever a medication is held for any reason, the hour it was held must be initialed and circled in the Medication Administration Record (MAR) by the responsible Licensed Nurse. The Licensed Nurse will document on the back of the MAR, noting the time and reason the medication was held. If the PRN (as needed) is for complaint of pain, the Nurse will document the pain score prior to giving the medication and after administration of the pain medication. If resident is refusing to take medication, time of refusal must be circled in the Medication Administration Record (MAR) and initialed by the Licensed Nurse who is passing meds (medications) and documentation will be entered on the back of the MAR stating the reason for the refusal. The Licensed Nurse will attempt to give the medications several times, but if resident continues to refuse after one hour, the refused medications will be destroyed. Licensed Nurse will notify M.D. (physician) and document in the medical record. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. During an observation and concurrent interview on 5/26/2021, at 12:17 p.m., with DON, on the East Nursing Station, the DON stated licensed nurses are supposed to pass medication to residents within one hour of the scheduled medication administration time. DON stated if the administration time is 9 a.m. the Licensed Nurse may pass medications starting at 8 a.m. until 10 a.m., DON stated if medications are passed outside that time frame, the responsible nurse must notify the physician before administering a late medication to get prior approval from the physician. DON stated if a blood pressure medication is late for administration the resident's vital signs (reflect essential body functions, including heartbeat, breathing rate, temperature, and blood pressure) may need to be taken and documented on a change of condition (COC) form. DON stated the Licensed Nurse must document the date and time of the late administration on the resident's MAR, notify the physician and document in the nursing progress notes that the physician was made aware including details related to the late administration and physician orders. While interviewing the DON LVN 3 was observed in the hallway passing medications. Upon interview, LVN 3 stated he was passing medications for Resident 61 which were scheduled for 9 a.m. with the medications scheduled at 12 p.m. DON asked LVN 3 if he had notified the physician and received approval to administer the medications late. DON stated she was not notified by the licensed nurses that residents' medications were being administered late, outside the one hour before or one hour after scheduled administration time. DON stated residents not receiving their medications as ordered could experience a change of condition, loss of control of blood pressure, blood sugar, potential to experience more anxiety or depression depending on which medication is not administered timely and could lead to resident harm, hospitalization or death. During an interview with the DSD/IP, on 5/26/2021, at 2:22 p.m., the DSD/IP stated after 10 a.m. Residents 15, 23, 31, 45, 56, and 61 were identified to have been administered the 9 a.m. medications late on the East Nursing Station. A review of the facility's policies and procedures titled, Medication Administration, revision date 1/2012, indicated, Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. The Licensed Nurse will prepare medications within one hour of administration. Medications may be administered one hour before or after the scheduled medication administration time. 4. During a Medication Cart Inspection on the Middle Nursing Station, MedCart 1, on 5/27/2021, at 10:48 a.m. , with LVN 2, LVN 2 stated the Middle MedCart is shared with another nurse that has residents on the East Nursing Station. LVN 2 stated they each have a key to the shared Middle MedCart. LVN 2 stated she had completed her morning medication pass before 10 a.m. but did not know if the other nurse who shared her MedCart had completed her morning medication administrations for the 9 a.m., administration time. During a concurrent interview and record review, on 5/27/2021, at 10:55 a.m., with LVN 2, Residents (56, 15, 45, 61, 31, and 23) Medication Administration Record (MAR), dated May 2021 was reviewed. 4a. The MAR indicated, on 5/26/2021 and 5/27/2021, for the 9 a.m. administration time, there were no licensed staff initials in the box for Resident 56's Aspirin 81 mg, Magnesium Oxide (supplement) Tablet 400 mg, Artificial Tears (treat dry eyes) Solution 1.4%, Docusate Sodium (stool softener) 100 mg capsule, and Oscal 500mg/ 200 mg Vitamin D (supplement) Tablet to demonstrate the medications were administered. LVN 2 stated there was no documentation on the MAR for 5/2021, that indicated Resident 56 received the Aspirin, Magnesium Oxide, Artificial Tears, Docusate Sodium, or Oscal with Vitamin D on 5/26/2021 and on 5/27/2021 at 9 a.m. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 56's Admission Record indicated Resident 56 was admitted to the facility on [DATE] with diagnoses including dementia. A review of Resident 56's H&P, dated 4/27/2021, indicated, resident can make needs know but cannot make medical decisions. A review of the facility's P&P titled, Medication - Verification,' revision date 1/2012, indicated, Medications are administered safely and appropriately as ordered. 4b. A review of the MAR indicated, on 5/27/2021, for the 9 a.m. administration time, there were no licensed staff initials in the box for Resident 15's Aspirin 81 mg, Benazepril (medication used to treat high blood pressure) 20 mg, Docusate Sodium 200 mg, Fenofibrate (medication used to treat high cholesterol) 160 mg, Vitamin B-12 (supplement) 1000 micrograms (mcg), Vitamin D3 (supplement) 25 mcg, to demonstrate the medications were administered on 5/27/2021 at 9 a.m. LVN 2 stated, there was no documentation on the MAR for 5/2021 that indicated Resident 15 received the above medications on 5/26/2021 and on 5/27/2021 at 9 a.m. A review of Resident 15's Admission Record indicated Resident 15 was admitted to the facility on [DATE] with diagnoses including history of falling, diabetes, schizophrenia, hypertension, and muscle weakness. A review of Resident 15's H&P, dated 5/19/2021, indicated, resident can make needs known but cannot make medical decisions. A review of the facility's P&P titled, Medication -Verification,' revision date 1/2012, indicated, Medications are administered safely and appropriately as ordered. 4c. A review of Resident 45's Admission Record indicated Resident 45 was readmitted to the facility on [DATE] with diagnoses including chronic pain, muscle weakness, cognitive communication deficit, hypertension, neuralgia (chronic nerve pain) and neuritis (Inflammation of nerves). A review of Resident 45's H&P, dated 11/16/2020, indicated, resident can make needs known but cannot make medical decisions. On 5/27/2021 at 10:55 a.m., during an interview with LVN 2 and concurrent review of Resident 45' MAR for 5/26/2021 and 5/27/2021, indicated that a total of 12 medication scheduled for 9 a.m., did not have documentation (licensed nurses' initials) to indicate the medications were given as order. The medication were: Aspirin 81 mg, cholecalciferol (Vitamin D3 supplement) 3000 units, Cymbalta (treatment for depression) 90 mg, capsule, Donepezil (treatment for dementia) 10 mg, Losartan Potassium (treatment for high blood pressure) 50 mg, Lumigan Solution (treatment for Glaucoma, an eye conditions that can cause blindness) 0.01 %, Artificial Tears Solution (for dry eyes) 1 %, Divalproex Sodium (treatment for mental disorder), 250 mg, Docusate Sodium 100 mg, Fluticasone-Salmeterol Aerosol (treatment for difficulty breathing) 100-50 mcg/dose, PreserVision Areds (vitamin supplement to support vision health), and Clonidine (treatment for high blood pressure) 0.1 mg., LVN 2 stated, there was no documentation on the MAR for 5/2021 that indicated Resident 45 received the above medications on 5/26/2021 or 5/27/2021 at 9 a.m. A review of th [TRUNCATED]

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on interview and record review, the facility failed to ensure one of five sampled residents, (Resident 4), investigated addressing unnecessary psychotropic (any drug capable of affecting mood, emotions, behavior), medications were adequately monitored. The facility failed to: 1. Ensure Resident 4 did not received duplicate sedative therapy at bedtime on 05/06/2021, 05/07/2021, 05/08/2021, 05/11/2021, 05/12/2021, 05/13/2021, 05/14/2021, 05/21/2021, 05/28/2021, 05/29/2021, and 05/30/2021 when Klonopin (Clonazepam, a psychotropic medication used for anxiety disorder [an intense, excessive, and persistent worry and fear about everyday situations]) and Ambien (a sedative-hypnotic medication indicated for sleep) were administered nightly at the same time. 2. Document nonpharmacological interventions prior to and in addition to as needed medication administration of Ambien for inability to sleep for Resident 4 to include effectiveness or ineffectiveness of the interventions prior to the administration of Ambien to Resident 4. 3. Ensure a gradual dose reduction ([GDR] a periodic attempt to reduce the dosage of a medication to the lowest effective dose or to discontinue the medication) was performed on Ambien for Resident 4. These deficient practices had the potential to result in Resident 4 experiencing adverse side effects related to antipsychotic medication use including sedation (drowsiness), dizziness, blurred vision, restlessness, muscle spasms, and confusion. Use of antipsychotic medication can increase the risk of stroke and can lead to fall and injuries, that are associated with higher rates in death in the elderly. Findings: A review of Resident 4's Face Sheet (Admission Record) indicated Resident 4 was readmitted to the facility on [DATE], with diagnoses including anxiety disorder and dependence on renal dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). A review of Resident 4's Health and Physical (H&P) Examination (the initial clinical evaluation and examination of the resident) dated 05/19/2021 indicated Resident 4 had the capacity to understand and make decisions. A review of Resident 4's Order Summary Report, dated 06/01/2021, indicated that resident was ordered by his physician: a. Ambien 10 mg (Milligrams - unit of measure) by mouth every 24 hours as needed for insomnia manifested by inability to sleep at bedtime, order date of 02/02/2020 (continued on next page)

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	055060	A. Building B. Wing	06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Post Acute Care	12121 Santa Monica Boulevard Los Angeles, CA 90025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Clonazepam 1 mg by mouth at bedtime for anxiety manifested by verbalization of anxiousness (an Intense, excessive and persistent worry and fear about everyday situations), order date of 01/03/2020 A review of Resident 4's May 2021 Medication Administration Record (MAR, a legal record of the drugs administered to a patient at a facility by a health care professional), indicated that resident received Clonazepam 1 mg and Ambien 10 mg (two sedating medications) nightly at 9 p.m. eleven times during the month of May 2021. On the following dates, 05/06/2021, 05/07/2021, 05/08/2021, 05/11/2021, 05/12/2021, 05/13/2021, 05/14/2021, 05/21/2021, 05/28/2021, 05/29/2021, and 05/30/2021. During a concurrent interview and record review on 06/01/2021, at 12 p.m., with Director of Staff Development/Infection Preventionist (DSD/IP), Resident 4's May 2021 MAR was reviewed. Resident 4's May 2021 MAR indicated the number of hours the resident slept nightly and the number of episodes when the resident verbalized anxiety during the month of May 2021. The DSD/IP stated Resident 4's May 2021 MAR indicated the resident slept two to three hours during the 3 p.m. to 11 p.m. shift daily and averaged 7 hours of sleep during the 11 p.m. to 7 a.m. shift nightly. The May 2021 MAR indicated zero episodes of verbalization of anxiety by Resident 4 across the three different nursing shifts (7 a.m. to 3 p.m., 3 p.m. to 11 p.m., and 11 p.m., to 7 a.m.). During a concurrent interview and record review with DSD/IP, on 06/01/2021, at 12:07 p.m., the DSD/IP stated there was no documentation on that back of Resident 4's May 2021 MAR of what nonpharmacological interventions tried or effectiveness of any interventions prior to administering Ambien to the resident. DSD/IP stated the Resident 4's nursing progress notes did not document any non-drug interventions to assist resident in falling asleep prior to administering the resident's as needed order of Ambien. During an interview with the Minimum Data Set Nurse/Licensed Vocational Nurse (MDS/LVN), on 06/01/2021, at 12:40 p.m., the MDS/LVN stated Resident 4's overflow clinical records was reviewed. The MDS/LVN stated, there was no order to decrease Resident 4's Ambien ordered on 2/2/2020 by the physician with instructions to administer Ambien 10 mg by mouth every 24 hours as needed for Resident 4. During a review of facility's Pharmacist Consultant Monthly Medication Regimen Review for Resident 4, dated 03/27/2021, Pharmacist Consultant recommendation indicated, Resident (4) has an order for Ambien 10 mg nightly at bedtime as needed (caution for high dose of 10 mg). Per CMS regulations, PRN (as needed) psychotropic orders are limited to 14 days. If longer duration of this PRN antipsychotic order is required, please include the documentation in the clinical record. Under Physician/Prescriber Response the box indicating disagree was marked and the received provided was, Patient refuse any GDR (gradual dose reduction). The form signed and dated 04/02/2021. During an interview with Resident 4, on 06/01/2021, at 12:45 p.m., Resident 4 walked independently to the nursing station. Resident 4 stated he sleeps well except when his roommate screams and yells at night keeping him up. Resident 4 stated he leaves early for Dialysis three times a week on Monday, Wednesday, and Friday and his appointment time is 4 a.m. Resident 4 stated he sleeps well when his roommate is quiet. Resident 4 stated he has not refused to change any of his medications. Resident 4 stated, I follow whatever order the physician prescribes. I am taking so many medications I cannot remember all the names of the medications. I just follow the orders of the prescriber. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/01/2021, at 2:37 p.m., with Director of Nursing (DON), DON stated there was not order for a GDR for Resident 4's Ambien, it looked more like a suggestion than an attempt to reduce the Ambien dose. DON stated the licensed nurses should do nonpharmacological intervention first prior to administering the PRN medication Ambien. DON stated nonpharmacological intervention should include turning down the lights and creating a quiet environment for Resident 4. A review of Resident 4's Care Plan for Ambien, dated 05/24/2021, indicated, Monitor for dose reduction. Use non-pharmacological approaches: Prove a quiet and calm environment. A review of Resident 4's Care Plan for Clonazepam, dated 05/24/2021, indicated, The resident is taking anti-anxiety medications which are associated with an increased risk of confusion, amnesia (inability to remember), loss of balance, and cognitive impairment that looks like dementia, falls, broken hips and leg. Monitor every shift for safety. Use non-pharmacological approaches .Teach resident relaxation techniques or deep breathing exercises. During an interview on 06/02/2021, at 11:52 a.m., with Nurse Practitioner (NP 1) for Resident 4, NP 1 stated Resident 4 for was seen by him for the first time on 04/02/2021. NP 1 stated the facility's nursing staff should know to separate the Clonazepam and Ambien by three hours. NP 1 stated Clonazepam and Ambien should not be administered at the same time. NP 1 stated the facility should evaluate and provide nonpharmacological interventions and the environment may be a factor for Resident 4 not sleeping well. NP 1 stated Resident 4 could develop a dependency on the medications and should not be on these medications for a long time. NP 1 stated the input of the nurses are very important. NP 1 stated the reason why we do GDR is because controlled medication have inherent side effects and can lead to tolerance and dependence. NP 1 stated Resident 4 has been at the facility for years with no GDR done and this was the first time NP 1 saw the resident. NP 1 stated Resident 4 is on dialysis, which is another concern for resident safety, and he (NP 1) will have to see the Resident 4 again to reevaluate the resident's use and time of the medication administrations of Klonopin and Ambien. During an interview with DON, on 06/02/2021, at 1:03 p.m., the DON stated Ambien and Clonazepam administration time should have been separated and the licensed nurses should have documented nonpharmacological intervention attempts and included if the interventions were effective based on the Resident 4's care plan. A review of the facility's policy and procedures titled, Behavior/Psychoactive Drug Management, with revised date of 11/2018, indicated, Hypnotic medications - These medications are used to help residents sleep if there is no other way they can sleep. The Licensed Nurse will notify and collaborate with the Attending Physician/Prescriber, family, resident, Responsible Party, and/or IDT (Interdisciplinary Team) members regarding identified contributing factors to the resident's mood/behavior problems and the non-drug interventions taken to address the problems, as well as to evaluate the effectiveness of the non-drug interventions for further recommendations. The Licensed Nurse will document the interventions taken and recommendations in the resident's Care Plan. Dose reduction or re-evaluation are provided according to OBRA (Omnibus Budget Reconciliation Act) regulations: Anti-anxiety medications - every 4 months of continuous use. Hypnotics - after 14 days of continuous use. These medications should be used short-term unless prescribed for endogenous (having an internal cause or origin) insomnia.

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five percent (5%). During the medication pass observation on 5/27/2021, eight medication errors were observed of a total of 30 opportunities for error (a total of 30 medications were observed administered or missed [omitted] for one of four sampled residents (Residents 10). Eight medications were not given within one hour from the scheduled 9 a.m. time (considered medication error), and two medications were omitted (Gabapentin [Neurontin] medication to treat nerve pain and Basaglar KwikPen Pen Injector [Insulin pen to control blood sugar]) for a total of 10 medication errors. This deficient practice resulted in an overall medication error rate of 33.33% placing Resident 10 at risk of complications including not maintaining therapeutic range levels (the amount of drug levels in the blood in which a drug has the desired effects upon the body) and had the potential to result in Resident 10 experiencing increase in anxiety, depression, uncontrolled blood pressure and elevated blood sugar, and heart attack, or death. On 5/26/2021, at 5:57 p.m., the Director of Nurses (DON), Assistant Director of Nursing (ADON), and the Administrator (ADM) were verbally notified of an Immediate Jeopardy (IJ: a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) situation. The IJ situation was declared due to delayed in administering the medication as per scheduled time and omitting two medications, placing the resident at risk for high blood pressure, heart disease, pain, and high or low blood sugar levels. On 5/28/2021 at 2:20 p.m., the facility's Plan of Action (POA) was accepted after an onsite validation through observations, interviews, and record reviews and the IJ was lifted in the presence of DON and ADM. The POA included the following: 1. Assessed Resident 10 for any adverse effects related to the missed or late medication administration. All medications administered late were documented and physicians were notified. 2. DON and Regional Nurse Consultant (RNC), and Pharmacy Nurse Consultants (PNC), provided in-service to licensed nurses regarding facility's policy and procedures on medication administration followed by medication administration competency validation. DON and Director of Staff Development (DSD) provided skilled competency validation, observation, and return demonstration for medication administration for current licensed nursing staff. 3. DON, ADON, and PNC reviewed the remaining 72 residents for timely medication administration. 4. Pharmacy Consultant/Licensed Nurse Designee will continue to conduct Medication Pass Observations with return demonstration for Licensed Nursing staff. Findings: (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Admission Record indicated the facility originally admitted the resident on 4/2/2013 and readmitted on [DATE], with diagnoses including, heart failure, hypertension (a condition in which the force of the blood against the artery walls is too high), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), diabetes (a group of diseases that result in too much sugar in the blood [high blood glucose], depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily functioning), muscle weakness, and dysphagia (difficulty swallowing). On 5/25/2021, at 11:06 a.m., a Medication Pass (MedPass) observation of Licensed Vocational Nurse 3 (LVN 3) at the East Nursing Station was initiated. LVN 3 was preparing and administering the following medications for Resident 10 orally (by mouth): 1. Aspirin low dose enteric coated 81 mg (milligrams - unit of measure) one tablet (for prevention of heart attack). 2. Digoxin 0.125 mg one tablet (for irregular heartbeat). 3. Metoprolol Succinate ER 50 mg one tablet (white round tablet with drug imprint 565 [pill imprint code is used to uniquely identify all solid oral dosage forms such as tablets, capsules, and pills]) for hypertension. 4. Multiple Vitamin One Daily one tablet (red tablet) as supplement. 5. Vitamin C 500 mg one tablet as supplement. 6. Zinc Sulfate 220 mg one tablet as supplement. 7. Sertraline (Zoloft) 50 mg one tablet for depression(a common and serious medical illness that negatively affects how the person feels, the way they think and how they act). 8. Famotidine (Pepcid) 20 mg one tablet for GERD (gastroesophageal reflux disease - a digestive disorder, occurs when stomach acid flows back into the tube [esophagus] connecting the mouth and stomach). On 5/25/2021, at 11:18 a.m., during interview and concurrent review of the Medication Administration Record (MAR) for the medications above listed and LVN 3 stated Resident 10 was administered eight medications, which was all were scheduled 9:00 a.m. (morning medications for 5/25/2021). A review of Resident 10's Medication Administration Record (MAR) for 5/2021, included the following prescribed orders: 1. Ordered start date 2/19/2021 - Aspirin 81 one time a day by mouth for. Take with food, scheduled administration time 9:00 a.m. However, Aspirin 81 mg medication was observed administered on 5/25/2021, at 11:06 a.m., two hours after scheduled administration time of 9 a.m. and not observed administered with food as ordered. (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Ordered start date 3/28/2021 - Digoxin 0.125 mg one time a day by mouth for atrial fibrillation (irregular heartbeat) related to heart failure. Hold if apical pulse (pulse taken on the left side of the chest over the heart) is less than 60 heartbeats per minute, scheduled administration time 9:00 a.m. However, Digoxin 0. 125 mg medication was observed administered on 5/25/2021, at 11:06 a.m., two hours after scheduled administration time of 9 a.m. 3. Ordered start date 2/19/2021 - Metoprolol-Hydrochlorothiazide (combined antihypertensive medications metoprolol and hydrochlorothiazide [diuretic, water pill]) ER (Extended Release) 24 Hour 50 mg/12.5 mg one tablet by mouth one time a day, scheduled administration time 9:00 a.m. Metoprolol Succinate 50 mg ER without Hydrochlorothiazide 12.5 mg (wrong medication) was administered on 5/25/2021, at 11:06 a.m., two hours after scheduled administration time of 9 a.m. 4. Ordered start date 2/19/2021- multi-vitamin with minerals one tablet by mouth one time a day for supplement, scheduled administration time 9:00 a.m. Multivitamin without minerals (wrong medication) was observed administered on 5/25/2021, at 11:06 a.m., two hours after scheduled administration time of 9 a.m. 5. Ordered start date 2/28/2021 - Vitamin C 500 mg one tablet by mouth in the morning for supplement, scheduled administration time 9:00 a.m. Vitamin C 500 mg was observed administered on 5/25/2021, at 11:06 a.m., two hours after scheduled administration time of 9 a.m. 6. Ordered start date 2/28/2021 - Zinc Sulfate 220 mg one tablet by mouth in the morning for supplement, scheduled administration time 9:00 a.m. Zinc Sulfate 220 mg medication was observed administered on 5/25/2021, at 11:06 a.m., two hours after scheduled administration time of 9 a.m. 7. Ordered start date 2/19/2021 - Sertraline (Zoloft) 50 mg one tablet by mouth one time a day for depression manifested by verbalization of sadness, scheduled administration time 9:00 a.m. Sertraline 50 mg medication was observed administered on 5/25/2021, at 11:06 a.m., two hours after scheduled administration time of 9 a. m. 8. Ordered start date 2/19/2021 - Famotidine (Pepcid) 20 mg one tablet by mouth two times a day for GERD, scheduled administration times 9:00 a.m. and 9 p.m. However, Famotidine 20 mg medication was observed administered on 5/25/2021, at 11:06 a.m., two hours after scheduled administration time of 9 a.m. 9. Ordered start date 2/19/2021 - Gabapentin (Neurontin) 600 mg one tablet by mouth three times a day for Neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet) scheduled administration time 9:00 a.m., 1:00 p.m., and 5:00 p.m. Gabapentin 600 mg was not observed administered during morning medication pass observation to Resident 10 on 5/25/2021, for the 9 a.m. administration time. 10. Ordered start date 5/14/2021 - Basaglar KwikPen Pen Injector 100 units per ml, Inject 40 units subcutaneously (just under the skin) two times a day for diabetes. Hold if blood sugar less than 100 mg per deciliters (mg/Dl). Rotate site, scheduled administration times 9:00 a.m. and 5:00 p.m. Basaglar Kwikpen Pen Injector 40 units was not observed administered during morning medication pass observation to Resident 10 on 5/25/2021, for the 9 a.m. administration time. (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/25/2021, at 11:30 a.m., during an interview, LVN 3 stated, the eight medications (Aspirin 81 mg, Digoxin 0.125 mg, Metoprolol Succinate ER 50 mg [imprint on tablet 565, white round tablet], Multiple Vitamin One Daily, one tablet [red tablet], Vitamin C 500 mg, Zinc Sulfate 220 mg, Sertraline (Zoloft) 50 mg, and Famotidine (Pepcid) 20 mg) administered to Resident 10 starting at 11:06 a.m. on 5/25/2021, were the resident's morning medications scheduled for 9 a.m. administration. LVN 3 stated, he was late passing medications to Resident 10, and he had five more residents' rooms to go to complete the 9 a.m. scheduled medication administrations. On 5/26/2021, at 2:29 p.m., during an interview with LVN 3 and concurrent MAR review for Resident 10's 9 a. m. scheduled medications, there were no licensed staff initials (indicating the medication administration) in the boxes for Resident 10's Basaglar Kwikpen or Gabapentin 600 mg tablet. LVN 3 stated Resident 10's Gabapentin was unavailable for administration on 5/25/2021 and again on 5/26/2021. LVN 3 confirmed he had not administered resident's Basaglar Kwikpen injection. On 5/26/2021 at 12:17 p.m., during an interview, DON stated the facility's licensed nurses were supposed to pass medication to the residents within one hour before or within one hour after the scheduled time for medication administration. DON stated medication scheduled for administration to a resident at 9 a.m., the nurse may pass medications starting at 8 a.m. until 10 a.m. A review of the facility's policy and procedures titled, Medication - Verification, revision date 1/2012, indicated, Medications are administered safely and appropriately as ordered. A review of the facility's P&P titled, Medication Administration, revision date 1/2012, indicated, To ensure accurate administration of medications for residents in the Facility. Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. The Licensed Nurse will prepare medications within one hour of administration. Medications may be administered one hour before or after the scheduled medication administration time. The seven rights of medication are: i. The right medication ii. The right amount iii. The right resident iv. The right time v. The right route vi. Resident has right to know what the medication does .

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview, and record review, the facility failed to ensure three of five sampled residents' medication regimen was free from significant medication errors (Residents 10, 11, and 269). This deficient practice jeopardized Residents 10, 11, and 269's health and safety by failing to administer necessary medications in accordance with the physician order and notifying physician when medications were not administered or unavailable to meet the needs of the residents. On 5/26/2021, at 5:57 p.m., the Director of Nurses (DON), Assistant Director of Nursing (ADON), and the Administrator (ADM) were verbally notified of an Immediate Jeopardy (IJ: a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) situation. The IJ situation was declared due to facility not administering resident medications as ordered by the physician for, high blood pressure, heart disease, heart failure, diabetes mellitus (A group of diseases that result in too much sugar in the blood), blood clots, thyroid deficiency (A condition in which the thyroid gland doesn't produce enough thyroid hormone), dementia (A group of thinking and social symptoms that interferes with daily functioning), pain, anxiety, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning), and schizophrenia (A mental disorder that affects a person's ability to think, feel, and behave clearly). The facility failed to provide documentation to verify residents' physicians were notified prior to late medication administration and timely for refused medication administrations or concerns related to missing initials on the Medication Administration Record (MAR- a legal record of drug administered to a resident), medication error over 5%, medication not given within time frame, no documentation supporting held medication, medication signed in MAR but observed not administered, incomplete documentation, instructions of medication administration not followed, and no pain assessment. On 5/28/2021 at 2:20 p.m., the third Plan of Action (POA) was accepted after an onsite validation of the POA through observations, interviews, and record reviews, the IJ lifted in the presence of DON and ADM notified the IJ was lifted. The POA included the following: 1. Assessed all the three residents involved for any adverse effects related to the missed or late medication administration. All medications administered late were documented and physicians were notified. 2. Residents involved assessed for pain and pain assessment documented in the resident's medical record. 3. DON and Regional Nurse Consultant (RNC), and Pharmacy Nurse Consultants (PNC), provided in-service to licensed nurses regarding facility's policy and procedures on medication administration followed by medication administration competency validation. DON and Director of Staff Development (DSD) provided skilled competency validation, observation, and return demonstration for medication administration for current licensed nursing staff. 4. DON, ADON, and PNC reviewed the remaining80 residents for timely medication administration. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. Pharmacy Consultant/Licensed Nurse Designee will continue to conduct Medication Pass Observations with return demonstration for Licensed Nursing staff. Findings: 1. During a concurrent observation on 5/25/2021, at 9:21 a.m., with Licensed Vocational Nurse (LVN 6), at the [NAME] Nursing Station Medication Cart, LVN 6 prepared and administered seven morning medications on 5/25/201, scheduled for 9:00 a.m. administration time to Resident 11 including: i. Vitamin C (supplement) 500 milligrams (mg- unit of measure), one tablet ii. Folic Acid (medication used to treat low blood cells) 1 mg - one tablet iii. Furosemide (used to reduce extra fluid in the body (edema) caused by conditions such as heart failure) 20 mg, one-half tablet (10 mg) iv Magnesium Oxide (supplement) 400 mg, two tablets (800 mg) v. Bupropion hydrochloride (HCL) sustained release (SR) (medication used to treat depression) 150 mg, one tablet vi. Zinc Sulfate (supplement) 220 mg, one tablet vii. Gabapentin (medication to treat nerve pain and seizures [sudden episodes of uncontrollable muscle tone or movements that includes stiffness, twitching or limpness]) 300 mg, three capsules (900 mg). During an interview with LVN 6, on 5/25/2021, at 9:38 a.m., LVN 6 stated he administered seven morning medications for Resident 11. LVN 6 stated Resident 11 was scheduled to have an antibiotic, Levofloxacin (Medication used to treat a variety of bacterial infections), but it was unavailable. A review of Resident 11's Admission Record indicated an original admitted d 11/6/2020 and a readmission on 2/15/2021 with diagnoses including hypertension (high blood pressure, a condition in which the force of the blood against the artery walls is too high), history of urinary tract infections, insomnia (difficulty falling or staying asleep), and depression. A review of Resident 11's Health and Physical (H&P) Examination (the initial clinical evaluation and examination of the resident) dated 4/25/2021 indicated Resident 11 had the capacity to understand and make decisions. A review of Resident 11's May 2021 MAR was conducted. The MAR for Resident 11 was initialed by a licensed nurse to indicated Resident 11 was administered Levofloxacin and Celebrex (medication to treat moderate pain) on 5/25/2021, at 9 a.m. administration time. (continued on next page)

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	055060	A. Building B. Wing	06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Post Acute Care	12121 Santa Monica Boulevard Los Angeles, CA 90025

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent interview and record review, on 5/26/2021, at 4:09 p.m., with Medical Records Supervisor (MRS), MRS provided Resident 11's prescription order for Levaquin (Medication used to treat a variety of bacterial infections) 500 mg, one tablet by mouth daily for seven days, dated 3/17/2021. The MRS stated she had reviewed Resident 11's clinical records and nursing notes and this was the last Levaquin order she could locate for Resident 11. The MRS further stated there were no nursing notes to indicate Resident 11's physician was called to clarify the Levofloxacin order or determined if the medication was still needed for the resident. During an interview with Resident 11, on 5/27/2021 at 3:54 p.m., Resident 11 stated she was not administered an antibiotic Levofloxacin or Celebrex on 5/25/2021, at 9:00 a.m. administration time. Resident 11 further stated the morning medications received on 5/25/2021 at 9:38 a.m., from LVN 6 were the medications administered while observed by the surveyor and LVN 6 did not return to give additional morning medications. Resident 11 further stated her antibiotic therapy had ended in 4/2021. 2. During Medication Pass (MedPass) observation on 5/25/2021, at 11:06 a.m., with LVN 3 at the East Nursing Station, LVN 3 was observed preparing and administering the following medications for Resident 10: i. Aspirin (Medication used to treat pain, fever, headache, and inflammation. It can also reduce the risk of heart attack) low dose enteric coated 81 mg, one tablet ii. Digoxin (Medication used to treat heart failure and heart rhythm problems) 0.125 mg one tablet iii. Metoprolol Succinate (Medication used to treat angina [chest pain] and high blood pressure) Extended Release (ER) 50 mg one tablet iv. Multiple Vitamin One Daily one tablet (red tablet) v. Vitamin C 500 mg one tablet vi. Zinc Sulfate (It is used as a dietary supplement to treat zinc deficiency) 220 mg one tablet vii. Sertraline (Zoloft) (Medication used to treat depression, social anxiety disorder, and panic disorder) 50 mg one tablet viii. Famotidine (Pepcid) (Medication that can be used to treat ulcers, gastroesophageal reflux disease [GERD- A digestive disease in which stomach acid or bile irritates the food pipe lining], and conditions that cause excess stomach acid) 20 mg one tablet During an interview with LVN 3, on 5/25/2021, at 11:18 a.m., LVN 3 stated Resident 10 was administered eight medications, which was all her scheduled 9:00 a.m., morning medications for 5/25/2021. During a review of Resident 10's MAR dated May 2021, the MAR including, not limited to the following prescribed orders was not observed administered to Resident 10 on 5/25/2021, for 9 a.m. administration time: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	i. Ordered start date 2/19/2021 - Gabapentin 600 mg one tablet by mouth three times a day for Neuropathy (Weakness, numbness, and pain from nerve damage, usually in the hands and feet), scheduled administration time 9:00 a.m., 1:00 p.m., and 5:00 p.m. Gabapentin 600 mg was not observed administered during morning medication pass observation to Resident 10 on 5/25/2021, for the 9 a.m. administration time. ii. Ordered start date 5/14/2021 - Basaglar (insulin, to control blood sugar) KwikPen Pen Injector 100 units per milliliter (units/ml- unit of measure), Inject 40 units subcutaneously (just under the skin) two times a day for Diabetes Mellitus. Hold if blood sugar less than 100. Rotate site, scheduled administration times 9:00 a. m. and 5:00 p.m. Basaglar KwikPen Pen Injector 40 units was not observed administered during morning medication pass observation to Resident 10 on 5/25/2021, for the 9 a.m. administration time. During concurrent interview and record review on 5/26/2021, at 2:29 p.m., with LVN 3, Resident 10's May 2021 MAR was reviewed. The May 2021 MAR indicated, on 5/25/2021, for the 9 a.m. administration time, there were no licensed staff initials in the boxes for Resident 10's Basaglar KwikPen Pen-injector 100 units/ml or Gabapentin 600 mg tablet, to demonstrate the medications were administered to Resident 10. LVN 3 stated Resident 10's Gabapentin was unavailable for administration on 5/25/2021 and on 5/26/2021. LVN 3 further stated he had not administered Resident 10's Basaglar KwikPen on 5/25/2021 at 9:00 a.m. administration time. LVN 3 further stated, he did not document anywhere the medicines were not give to Resident 10. LVN 3 further stated he did not sign the MAR and the medicines was not given. LVN 3 stated he did not document, notify the physician or let anyone know Resident 10 did not receive the medications (Gabapentin or Basaglar). LVN 3 stated the Gabapentin was for pain and Resident 10 complained about pain and the medication might have helped reduced her pain. During a review of Resident 10's 5/2021 MAR, blood sugar reading between 5/20/2021 through 5/25/2021, indicated Resident 10's blood sugar levels were high and not well controlled with the following blood sugar (BS) readings: On 5/20/2021 at 9:00 a.m., BS 212 and at 5:00 p.m., BS 319 On 5/21/2021 at 9:00 a.m., BS unclear documentation and at 5:00 p.m., BS 362 On 5/22/2021 at 9:00 a.m., BS 240 and at 5:00 p.m., BS 300 On 5/23/2021 at 9:00 a.m., BS 200 and at 5:00 p.m., BS 299 On 5/24/2021 at 9:00 a.m., BS 250 and at 5:00 p.m., BS 375 On 5/25/2021 at 9:00 a.m., BS not documented According to the World Health Organization, hyperglycemia, the term for expressing high blood sugar, has been defined as the blood glucose (blood sugar) levels greater than 126 milligram/deciliter (mg/dl- unit of measurement) when fasting (on an empty stomach); and blood glucose levels greater than 200 mg/dl, two hours after meals. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. A review of Resident 269's Admission Record indicated Resident 269 was admitted to the facility on [DATE] with diagnoses including heart failure, hypertension, atrial fibrillation (irregular heartbeat), pulmonary embolism(a blood clot that travels to the lungs), depression, and schizophrenia. A review of Resident 269's H&P, dated 4/24/2021, indicated, Resident 269 did not have the capacity to understand and make decisions. During a medication pass observation on 5/25/2021 at 9:43 a.m., LVN 6 took Resident 269's blood pressure and stated it measured 160 millimeters of mercury (mmHg- unit of measurement) (SBP, systolic blood pressure, the pressure of the blood in the arteries when the heart pumps) over 89 mmHg (DBP, diastolic blood pressure, the pressure between heat beats). According to the American Heart Association Hypertension Stage 2 is when blood pressure consistently ranges at 140/90 mm Hg or higher. At this stage of high blood pressure, doctors are likely to prescribe a combination of blood pressure medications and lifestyle changes. During a concurrent observation and interview with LVN 6, on 5/25/2021, at 10:04 a.m., LVN 6 stated Resident 269 refused all the morning medications because the Tylenol she requested was not added. LVN 6 further stated Resident 269 always refuse medications and he will change the MAR to resident refused and will waste the seven prepared medications. LVN 6 stated he would circle his initial, which means the resident did not take the medications. LVN 6 was observed placing Resident 269's medications in a sharps container for disposal was in the bottom of his medication cart. LVN 6 stated Resident 269's blood pressure was high (160/89) and acknowledged the medications disposed included blood pressure medications and blood thinners to prevent clots. LVN 6 further stated another medication (Divalproex Sodium [Medication is used to treat certain types of seizures (uncontrollable movement)] 125 mg) scheduled for 9:00 a.m. administration for Resident 269 was unavailable. LVN 6 stated Resident 269 physician was not notified Resident 269 frequently refused morning medications or Divalproex was unavailable for administration to Resident 269. LVN 6 further stated Resident 269's was supposed to receive one more morning medication, however, the medication was unavailable in the medication cart. LVN 6 showed an empty bubble pack (a medication pack with each tablet or capsule individually sealed and labeled with date) labeled for Resident 269 indicated the order was for Divalproex Sodium 125 mg capsule. Medications observed prepared for Resident 269 and wasted by LVN 6 included: i. Furosemide (Medication used to treat fluid retention (edema) and swelling) 20 mg, one tablet ii. Lisinopril (medication to control high blood pressure) 20 mg, one tablet iii. Multiple vitamins (supplement) - One Daily, one tablet iv. Sennosides (used to treat constipation) 8.6 mg, one tablet v. Eliquis (Apixaban, indicated for the prevention of deep vein thrombosis [DVT, blood clot in the leg], which may lead to pulmonary embolism [PE]) 5 mg, one tablet vi. Carvedilol (medication to control high blood pressure) 25 mg, one tablet (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	vii. Tums (Calcium Carbonate, use to treat heartburn or upset stomach) 750 mg, one tablet chewable. A review of Resident 269's 5/2021 Physician's Order Summary Report, indicated an order for Divalproex Sodium Capsule Delayed Release Sprinkle 125 mg, give two capsules (250 mg) by mouth in the morning for schizophrenia. A review of Resident 269's 5/2021 MAR indicated LVN 6 initialed and circled his initial to indicate Resident 269 had refused the Divalproex Sodium medication administration on 5/25/2021, for 9:00 a.m. administration time. During an interview with LVN 6 on 5/25/2021, at 10:04 a.m., LVN 6 stated Divalproex medication was unavailable during 9 a.m., administration time. During an interview with the DON, on 5/26/2021, at 12:36 p.m., the DON stated she was not notified by the LVN that residents' medications were being administered late, outside the one hour before or one hour after scheduled administration time. The DON further stated residents not receiving their medications as ordered could experience a change of condition, loss of control of blood pressure, blood sugar, potential to experience more anxiety or depression depending on which medication is not administered timely and could lead to resident harm, hospitalization or death. A review of the facility's policy and procedures (P&P) titled, Medication Administration - Refusing Medication, with revised of 1/2012, indicated, The Licensed Nurse will attempt to give the medications several times, but if resident continues to refuse after one hour, the refused medications will be destroyed. Licensed Nurse will notify M.D. (physician) and document in the medical record. A review of the facility's P&P titled, Medication-Verification,' with revision date of 1/2012, indicated, Medications are administered safely and appropriately as ordered. A review of the facility's P&P titled, Medication Administration, with revision date of 1/2012, indicated, Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. The Licensed Nurse will prepare medications within one hour of administration. Medications may be administered one hour before or after the scheduled medication administration time. A review of the facility's P&P titled, Medication Ordering and Receiving - Ordering and Receiving Medications from the Dispensing Pharmacy, effective date 2/2015, indicated, Reorder medications three days in advance of need to assure an adequate supply is on hand.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40541 Based on observation, interview, and record review, the facility failed to: 1. Maintain medication storage cabinet locked or under direct observation of authorized staff in an area where residents can access the medications, 2. Store orally administered medications separately from externally used medications, 3. Store medication labeled for individual resident (Resident 134) separately from floor stock medication, 4. Ensure vaccine medications for three residents (Residents 130, 126, and 127) Pneumovax (used to help prevent infections caused by certain types of germs or bacteria called pneumococcus) vaccine were stored at the correct temperature as required by the manufacturer's specification to maintain the integrity and effectiveness of the medication for residents use, 5. Ensure the removal of discontinued, expired, or medications not approved for resident administration for two current residents (Residents 130 and 268, and two discharged residents (Residents 418 and 419) from the medication carts, so they would not be available for use, and 6. Ensure medications were properly disposed according to the facility's policy and procedures. These deficient practices had the potential for medication diversion and potential for harm to other residents and of administrating a medication that is not potent to the residents. Findings: 1. During an observation on [DATE], at 8:00 a.m., observed medication storage double door cabinet located in the Yellow Zone (area in the facility where residents are observed for signs and symptoms of Coronavirus 2019 [COVID-2019, a severe respiratory illness caused by a virus and spread from person to person] COVID-19) staff charting room was unlocked and unattended. 2. During an observation on [DATE], at 8:07 a.m., observed one of the double doors of the medication storage cabinet located in the yellow zone staff charting room was wide open and unattended. During a concurrent observation, contents in the medication storage cabinet included Lovenox (Enoxaparin), an anticoagulant (blood thinner) that helps prevent the formation of blood clots) prescription medication labeled for Resident 134 was stored on the same shelf as over the counter (OTC) medications and Lactulose (medication taken to treat constipation) liquid oral solution. During a concurrent observation, the Lactulose oral solution was stored in the same bin and on top of the OTC medications, and several bottles of liquid nourishment and other supplies were also observed stored in the medication cabinet. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and a concurrent interview with Licensed Vocational Nurse 5 (LVN 5), on [DATE], at 8:08 a.m., LVN 5 entered the Yellow Zone staff charting room and walked past the medication cabinet to the desk located on the other side of the room. During, LVN 5 stated he left the medication cabinet open. During an observation on [DATE], at 11:37 a.m., observed yellow zone staff charting room medication storage cabinet storing Resident 134's Lovenox prescription medication, OTC medication, Lactulose oral solution, and bottles of liquid nourishment was unlocked and unattended. During an observation and concurrent interview on [DATE], at 2:44 p.m., LVN/Minimum Data Set Nurse (LVN/MDS) stated the medication storage cabinet must be locked. LVN/MDS further stated the medications must be stored separately. 3. A review of Resident 134's Facesheet (Admission Record) indicated Resident 134 was admitted to the facility on [DATE] with diagnoses including left foot cellulitis (a bacterial infection in the deeper layers of skin and the fat and soft tissue underneath) and normocytic anemia (a blood problem. It means you have normal-sized red blood cells, but you have a low number of them). A review of Resident 134's History and Physical Examination form, dated [DATE], indicated Resident 134's cognition was intact. A review of Resident 134's Detail Admission/Discharge Report, dated [DATE]-[DATE], indicated Resident 134 was discharged from the facility against medical advice (AMA) on [DATE]. During an observation, interview, and a concurrent record review with the Director of Staff Development/Infection Preventionist Nurse (DSD/IP), of Resident 134's box of Lovenox prescription medication located in the yellow zone staff charting room on [DATE], at 12:41 p.m., the DSD/IP stated Resident 134's Lovenox prescription medication, Lactulose liquid solution, and OTC medications must be stored separately. The DSD/IP stated Resident 134 was no longer at the facility. The DSD/IP further stated Resident 134's prescription medication should have been discarded when he was discharged from the facility. A review of the facility's policy and procedures titled Medication Storage in the Facility, dated [DATE], indicated medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel , or staff members lawfully authorized to administer medications .Orally administered medications are kept separate form externally used medications, such as liquids . Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart. 31333 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a concurrent observation and interview on [DATE], at 11:14 a.m., with Licensed Vocational Nurse (LVN 2) of the Middle Nursing Station Medication Cart 1, bottles of medications were observed inside the Medication Cart labeled for individual residents. LVN 2 stated the bottles were residents medication brought in with the residents from home (Home Medications) upon admission to the facility, but not approved by the physician or reviewed by the facility's pharmacy for resident use. LVN 2 stated the Home Medications, discontinued medications, and medications left behind after resident discharge was mixed in the medication cart with current resident's medications. The following issues with medication storage were identified: a. Three bottles of home medications labeled for Resident 268 was observed inside the medication cart that include: i. Gabapentin (medication used to treat nerve pain) 300 mg (Milligrams - unit of measure) ii. Methocarbamol (a muscle relaxant medication) 500 mg iii. Acetaminophen (an over-the-counter medication for pain) 500 mg b. A Semglee (insulin, a medication used to control blood sugar) Solution for Injection 100 units/ milliliter insulin pen labeled for a discharged resident (Resident 418) was observed in the bottom drawer of the medication cart mixed with topical creams, rectal suppositories, oral powder, and under disinfectant cleaning wipes. c. A 60 milliliter (ml) bottle of Morphine Sulfate (a controlled substance with a high potential for abuse or addiction, used for moderate to severe pain) 10 mg/ 5 ml labeled for a discharged resident (Resident 419). A review of the Resident 268's Facesheet (Admission Record) indicated the facility admitted the resident on [DATE]. During a concurrent interview and record review, on [DATE], at 11:20 a.m., with LVN 2, Resident 268's [DATE] Medication Administration Record ([MAR] - a legal record of drug administered to a resident) was reviewed. LVN 2 stated Resident 268 current orders did not include orders for Acetaminophen 500 mg or Methocarbamol. LVN 2 stated current directions for Resident 268's Gabapentin order was different from the Home Medications that indicated give Gabapentin 300 mg every 4 hours from the current physician order that indicated give Gabapentin 300 mg twice a day dosing. LVN 2 stated, Resident 268's Home Medications for should have been removed from the medication cart and destroyed. A review of Resident 418's Admission Record indicated the facility originally admitted the resident on [DATE], readmitted the resident on [DATE], and the resident was discharged to an acute care hospital on [DATE]. During an interview on [DATE]at 11:43 a.m., with LVN 2, LVN 2 stated Resident 418's Semglee Insulin Pen should have been stored removed from the medication cart stored separately until destroyed and not stored in the overflow drawer of the medication cart. LVN 2 stated Resident 418 discharged from the facility and had not returned. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 419's Admission Record indicated the facility originally admitted the resident on [DATE], readmitted the resident on [DATE], and the resident expired at the facility on [DATE]. During an interview on [DATE] at 11:50 a.m., with LVN 2, LVN 2 stated Resident 419 expired in the facility and the controlled medication Morphine should have been removed from the medication cart given to the Director of Nursing (DON) to be stored separately until destroyed by the DON. LVN 2 stated there was no Controlled Substance Count Sheet for the Morphine Sulfate liquid. LVN 2 stated the medication was not included in the daily controlled shift change audit to account for controlled medications before handing the medication cart key the next nurse. LVN 2 acknowledged the lack of accountability could lead to controlled medication drug diversion, loss, or misuse. 5. During a concurrent observation and interview on [DATE], at 12:10 p.m., with Director of Staff Development/Infection Preventionist (DSD/IP) of the Yellow Zone Medication Cart, The following issues with medication storage was identified: a. Four bottles of home medications labeled for Resident 130 observed inside the medication cart mixed with current residents non-controlled medications that included: i. Hydrocodone (a controlled substance with a high potential for abuse or addiction, used for moderate to severe pain) 5 mg/Acetaminophen (an over-the-counter pain relief medication) 325 mg ii. Topiramate (treat and prevent seizures [sudden episode of involuntary muscle movement] and prevent migraine headaches) 200 mg iii. Cyclobenzaprine (muscle relaxant, used to treat pain and stiffness) 10 mg iv. Ibuprofen (pain medication) 400 mg. During an interview on [DATE], at 12:14 p.m., with DSD/IP, DSD/IP stated, the bag of medications in the medication cart are Resident 130's Home Medications and not approved to administer to the resident. DSD/IP stated Resident 130's Home Medications should have been removed from the medication cart and given to the DON. DSD/IP stated there was no documentation to compare the original quantity of Resident 130 controlled medication upon admission to the quantity in the medication cart today. DSD/IP state she could not verify if all controlled medication Hydrocodone/Acetaminophen 5 mg/325 mg could be accurately accounted for the controlled substance was not included in the facility's daily controlled substance shift change audit. A review of Resident 130's Admission Record indicated the facility admitted the resident on [DATE] b. During a concurrent observation and interview on [DATE], at 12:27 p.m., with DSD/IP, observed in the top drawer of the Yellow Zone Medication Cart was three vials of Pneumovax Vaccines stored unrefrigerated in the medication cart and individually labeled for Resident 130, Resident 126, and Resident 127. The label on each vial indicated, Keep Refrigerated. DSD/IP stated the Pneumovax should have been stored upon delivery from the pharmacy immediately in the refrigerator. DSD/IP stated we will have to destroy the Pneumovax because the medications may no longer be effective if administered to the residents to prevent and protect Resident 130, Resident 126, and Resident 127 from contracting Pneumococcal disease, if contracted can place older adults at greatest risk of serious illness and death. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], the DON provided invoices from the facility's dispensing pharmacy that indicated the Pneumovax Vaccine was delivered for Resident 126, Resident 130, and Resident 127 and signed for at the facility on [DATE] at 9:36 a.m. During a review of the facility's policy and procedure (P&P) titled, Pneumococcal Disease Prevention, undated, indicated, To minimize the risk of Residents acquiring, transmitting or experiencing complications from pneumococcal disease. The facility will offer pneumococcal immunization to each Resident. During a review of the facility's P&P titled, Medication Storage in the Facility - Storage of Medications, effective date ,d+[DATE], indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendation .Medications requiring refrigeration or temperatures between 36 degree Fahrenheit and 46 degree Fahrenheit are kept in a refrigerator with a thermometer to allow temperature monitoring. Oral Medications are kept separate from externally used medications, such as suppositories, liquids and lotions. Discontinued or expired controlled medication (Schedule II - V) will be stored under double lock in the Director of Nurses' Office. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. A review of the facility's policy titled, Discontinued Medication, effective date ,d+[DATE], indicated, When medications are discontinued by a prescriber, a resident is transferred or discharged and does not take medications with him/her, or in the event of a resident's death, the medications are marked as 'discontinued' and destroyed. Medications awaiting disposal are stored in a locked secure area designated for that purpose until destroyed. Medications are removed from the medication cart immediately upon receipt of an order to discontinue (to avoid inadvertent administration). 6. During a concurrent interview and record review, on [DATE] at 11:36 a.m. with the DON, the non-controlled disposition logs reviewed between ,d+[DATE] through ,d+[DATE]. DON acknowledge there was no documentation of non-controlled drug disposal between ,d+[DATE] through ,d+[DATE]. The non-controlled disposal log for the month of ,d+[DATE] indicated one licensed nurse initial the disposition log. The DON stated the form indicated two nurses are required to dispose of discontinued medications. The facility's P&P titled, Medication Destruction, effective date ,d+[DATE], indicated, Non-controlled medication occurs only in the presence of two individuals, including, two licensed nurses .A pharmacist does not have to be there for the destruction, (2 LVN's or 1 LVN and 1 RN [Registered Nurse], etc.).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43243 Based on observation, interview, and record review, the facility failed to ensure cold, potentially hazardous foods were maintained at or below 41 degrees Fahrenheit (F) in a refrigerator in the kitchen. This deficient practice had the potential to result in rapid growth of bacteria that can cause foodborne illness (food poisoning) in 82 of 82 residents who consumed the food prepared in the kitchen. Findings: A review of the facility's document titled, Refrigerator/Freezer Temperature Log, dated May 2021, indicated the Continental 3-door refrigerator placed next to a coffee brewing machine's PM Temp (temperature measured in the evening) was measured at 43 F on 5/24/2021. During an observation and a concurrent interview with Dietary Supervisors 1 and 2 (DSs 1 and 2), on 5/25/2021, at 10:14 a.m., in the kitchen, DS 2 checked ambient temperature (air temperature) inside the Continental 3-door refrigerator, and it was measured at 46 F. The DS 1 stated staff would check PM Temp around 7:30 p.m. everyday. During an observation and a concurrent interview with DSs 1 and 2, on 5/25/2021, at 10:20 a.m., in the kitchen, DS 2 selected two random samples from the Continental 3-door refrigerator. DS stated the two samples were in the refrigerator overnight and untouched today. A cup of 4 oz of milk was measured at 46.4 F and a container full of soft cottage cheese was measured at 50.6 F. The refrigerator was mainly used for dairy products such as milk, yogurt, cheese, etc. During an interview with the DSs 1 and 2, on 5/25/2021, at 10:45 a.m., DS 2 stated they would discontinue using the Continental 3-door refrigerator until it was repaired. A review of the facility's policy and procedures titled, Refrigerator/Freezer Temperature Records, dated 11/1/2014, indicated The refrigerator temperature must be 41 F or below.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility's QAA (quality assessment and assurance) committee failed to develop and implement appropriate actions to correct identified quality deficiencies for pharmaceutical services, medication pass error rate and comprehensive care plan (cross referenced to F656, F755 and F759). These ongoing deficient practices of the facility not identifying quality concerns and correcting, as stipulated in the facility's plan of correction (CMS [Centers for Medicare and Medicaid Services] 2567), and the facility's policy, dated 7/16/21, for F656, F755, and F759, resulted in ongoing identified deficient practices and put the residents at risk for adverse consequences. Findings: A review of the facility's last survey CMS 2567 with a plan of correction (POC) dated 7/16/21, indicated the facility was cited for pharmaceutical services, medication pass error rate and comprehensive care plan. A review of the CMS 2567 (POC), dated 7/16/21, indicated the interdisciplinary ([IDT] coordinated group of experts from several different fields who work together toward a common resident goal) included the following: 1. The Director of Nursing (DON) or designee completed education with Licensed Staff regarding the policy of Comprehensive Care Plans . The facility's POC also indicated audit tool findings will be reviewed by the Director of Nursing/Assistant Director of Nursing (DON)/(ADON) during the morning stand-up meeting (Monday thru Friday) for 3 months (F656). 2. The Resource Nurse and specialist provided education on the staffs on Medication Administration Policy and Procedures emphasizing following the rights of Medication Administration, properly identifying patients prior to administration, timely administration, properly assessing patients pain levels, medication refusals, properly documenting late administration and refusals, and notifying the attending physician promptly prior to medication administration when medications are anticipated to be administered late or omitted. The POC also audit tool findings will be reviewed by the DON/ADON during morning stand-up meeting (Monday thru Friday) for 3 months. Administrator will report any findings to the QAPI Committee for further recommendation if needed monthly x3 months (F755). 3. The DON & Regional Nurse Consultants provided in-service to 3-11 charge nurses regarding facility policy and procedure on medication administration followed by a medication administration competency validation and the evidence of completion was submitted (F759). On 8/26/17 at 1:55 p.m., during an interview the administrator and the director of nursing (DON) stated they had worked on all the deficiencies and thought they were corrected. The DON stated that in-service and education for the staffs are ongoing and they keep track of identified issues during their standup and standdown meeting with clinical educators. The DON further stated they have corrected the deficiencies with the set target date and goals. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure, undated and titled, 2021 Quality Assurance & Performance Improvement (QAPI) Plan for Country Villa [NAME], indicated Country Villa [NAME] uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. Country Villa [NAME] applies a thorough and highly organized/structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. The QAA committee has the full authority to oversee the implementation of the QAA programs, including, but not limited to: 1. Our organization uses quality assurance and performance improvement to make decisions and guide our day-to-day operation; 2. The outcome of QAPI in our organization is to improve the quality of care and the quality of life of our residents; and 3. Our organization sets goals for performance and measures progress toward those goals.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40541 Based on observation, interview, and record review, the facility failed to ensure: 1. Staff secured isolation gowns before entering the yellow zone. 2. Maintain proper infection control measures for 18 of sixty-one sampled residents (Residents 4, 32, 34, 58, 119, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133) during COVID-19 (a severe respiratory illness caused by a virus and spread from person to person) pandemic (worldwide). 3. Used approved EPA (Environmental Protection Agency (EPA - an agency of the United States federal government whose mission is to protect human and environmental health approved) to disinfect surfaces/equipments/containers. This deficient practice had the potential for further spread of COVID-19 and other infections among residents, staff, and guests. Findings: 1. During an observation on 05/24/2021 at 7:53 a.m., Receptionist 2 (RC 2) and Central Supply 1 (CS 1) entered the facility without face masks (face covering), walked past the receptionist desk to the personal protective equipment (PPE - protective clothing, goggles, head/shoe covers, mask, gown, gloves or other garments or equipment designed to protect the wearer's body from infection) cart located in the lobby area, and donned (put on) masks without performing hand hygiene. Concurrently, RC 2 walked behind the reception counter located in the lobby, and CS 1 entered the facility basement area through a door located in the lobby without checking their temperature or screening for signs and symptoms of Coronavirus 2019. During a concurrent interview, CS 1 stated he would return to the lobby to take his temperature and screen for signs and symptoms of COVID-19 later. During an interview on 05/24/2021 at 7:54 a.m., Receptionist 1 (RC 1) stated, CS 1 should have checked his temperature, screened for signs and symptoms of COVID-19, and sanitized his hands prior to donning on a mask and entering the facility. During an observation on 05/24/2021 at 7:56 a.m., the Maintenance Supervisor 1 (MP 1) wore a mask under his nose while donning on a face shield and speaking with RC 1 in the lobby. During an observation on 05/24/2021 at 8:06 a.m., Certified Nursing Assistant 7 (CNA 7) did not tie and secure his isolation gown at the waist when entering a yellow zone (area in the facility where residents are observed for signs and symptoms of COVID-19) room to pass breakfast tray to Residents 125 and 132. During an observation on 05/25/2021 at 6:08 a.m., the Activity Assistant (AA) entered the facility, measured her temperature and, screened herself for signs and symptoms of COVID-19, did not sanitize the thermometer, or performed hand sanitizing prior to donning a mask or face shield. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/26/2021 at 7:55 a.m., AA stated she took her temperature and screened self for signs and symptoms of COVID-19 on 5/25/2021 without disinfecting the thermometer or sanitizing her hands prior to donning a mask or face shield. During an observation on 05/27/2021 at 7:48 a.m., CNA 5 entered the facility not wearing a mask, walked past the receptionist desk to PPE cart located in the lobby, and donned a mask without performing hand hygiene. During an observation on 05/27/2021 at 1:44 p.m., Laundry Services Attendant (LSA) was pushing contaminated laundry bin without wearing gloves. During an observation on 05/27/2021, at 1:46 p.m., LSA reentered facility after taking soiled linens outside the building, closed facility door, and began pushing dirty linen bin through the hallway without performing hand hygiene or wearing gloves. During an observation on 05/27/2021 at 2:26 p.m., LSA was observed with a plastic spray bottle labeled Sprayer Aspersor with unidentified clear liquid inside. The spray bottle did not have an EPA number on the label. During a concurrent interview, LSA further stated the unidentified clear liquid was an all-purpose cleaner, and uses the cleaning liquid labeled Sprayer Aspersor (not an cleaner to clean the laundry counters, bins and bibs instead of the provided germicide (substance or process that kills germs (bacteria, viruses, and other microorganisms that can cause infection and disease) bleach wipes. LSA further stated we should use a disinfectant that is EPA approved to disinfect the laundry counters, bins, and bibs for infection control. During an interview on 05/28/2021, at 9:05 AM., IP stated staff should be wearing surgical masks to enter the facility, perform hand hygiene before donning PPE, staff should take their temperature and screen prior to entering the facility for infection control. IP further stated staff should be donning their PPE properly, performing hand hygiene when indicated, wearing gloves when touching dirty bins, using EPA approved cleaners to disinfect, yellow and green residents should be smoking in their designated yellow and green zone areas, and not sharing cigarettes and lighters, or going through each other's rooms, and all residents, including yellow zone residents, should not be in the dining area at the same time staff are eating to prevent the spread of infection. During an interview on 06/02/2021, at 9:27 a.m., MP 1 stated the facility no longer used the Sprayer Aspersor) cleaner because the cleaner was not EPA approved. MP 1 further stated the facility uses bleach or the germicidal bleach wipes to prevent the spread of infection. 2. A review of the Facesheet indicated the facility initially admitted Resident 4 on 08/20/2017, and was readmitted on [DATE] with diagnoses including end stage renal (kidney) disease, diabetes mellitus (high levels of sugar in the blood) with diabetic chronic (long-term) kidney disease, dependence on renal dialysis, disorder of kidney and ureter (tube that carries urine from the kidneys to the bladder), atherosclerotic (narrowing of arteries due to plaque buildup on the artery walls) heart disease of native coronary (relating to the arteries which surround and supply the heart) artery without angina pectoris (chest pain), and hypertensive (pertaining to high blood pressure) chronic kidney disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 05/24/2021 at 12:14 p.m., MP 1 put his right arm around Resident 4 in yellow zone hallway while carrying a plastic bag of clean isolation gowns with his left hand and did not perform hand hygiene. MP 1 then put his right hand inside the plastic bag and removed clean isolation gowns and placed the isolation gowns into the PPE cart located outside Residents 123 and 124's room in the yellow zone and did not perform hand hygiene. In a concurrent interview at 12:15 p.m., MP 1 stated he did not perform hand hygiene after touching yellow zone Resident 4 and prior to restocking Resident 123 and 124's PPE cart with clean isolation gowns in the yellow zone. MP 1 further stated he should have performed hand hygiene after touching Resident 4 and prior to stocking PPE cart with clean isolation gowns to prevent spread of infection. 3. A review of the Facesheet indicated the facility admitted Resident 32 on 05/09/2021 with diagnoses including hypertensive heart disease, diabetes mellitus, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures (uncontrolled electrical activity in the brain, which may produce a physical convulsion), and generalized muscle weakness. 4. A review of the Facesheet indicated the facility admitted Resident 34 on 09/17/2021 with diagnoses including anoxic when your body or brain completely loses its oxygen supply) brain damage, nicotine dependence, intermittent (stopping and starting over a period of time) asthma (a condition in which a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe).and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures (uncontrolled electrical activity in the brain, which may produce a physical convulsion). 5. A review of the Facesheet, indicated the facility admitted Resident 58 on 04/30/2021 with diagnoses including Fournier gangrene (a rapidly progressing, tissue-destroying infection on the genitals and nearby areas), herpes simplex myelitis (a rare nervous system disease), human immunodeficiency virus (HIV - a virus that attacks the body's immune system) disease, and anogenital (venereal) warts (small lumps on the genitals caused by a common sexually transmitted infection). During an observation on 05/24/2021 at 8:43 a.m., CNA 8 did not tie her isolation gown when entering the yellow zone room, picked up Resident 58's meal tray, and the tray to CNA 7. 6. A review of the Facesheet (Admission Record) indicated the facility admitted Resident 125 on 05/10/2021. A review of the History and Physical (H&P) dated 05/12/2021, indicated Resident 125 had diagnoses including obesity (a disorder involving excessive body fat that increases the risk of health problems), coronary artery disease (CAD - damage or disease in the heart's major blood vessels), Cardiomyopathy (a disease of the heart muscle that makes it harder for your heart to pump blood to the rest of your body) with automatic implantable cardioverter defibrillator (AICD - a device that monitors a person's heart rate), and generalized muscle weakness. 7. A review of the Facesheet indicated the facility admitted Resident 127 on 05/16/2021 with diagnoses including seizures (uncontrolled electrical activity in the brain, which may produce a physical convulsion), encephalopathy (damage or disease that affects the brain), and thrombocytopenia (when a person does not have enough platelets, cells in your blood that stick together to help it clot). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 05/24/2021 at 8:43 a.m., CNA 8 did not tie her isolation gown when entering the yellow zone room to pick up trays for Resident127. 8. A review of the Facesheet indicated the facility admitted Resident 128 on 05/8/2021 with diagnoses including asthma, COPD, hypertensive heart disease with heart failure, and cellulitis (a common and potentially serious bacterial skin infection) of lower limb. During an observation on 05/24/2021 at 8:43 a.m., CNA 8 did not tie her isolation gown when entering the yellow zone room to pick up trays for Resident 128. 9. A review of the Facesheet indicated the facility admitted Resident 132 on 05/17/2021, with diagnoses including diabetes mellitus (high levels of sugar in the blood), hypertensive (pertaining to high blood pressure) heart disease with heart failure, anemia (a condition in which you lack enough healthy red blood cells to carry adequate oxygen to your body's tissues), and generalized muscle weakness. 10. A review of the Facesheet indicated the facility admitted Resident 119 on 05/20/2021, with diagnoses including seizures, cerebral edema (swelling in the brain caused by trapped fluid, multiple fractures of ribs, left side, fracture of left tibia (the main bone of the leg, forming what is more commonly known as the shin), fracture of lower end of the left femur (also called thighbone, upper bone of the leg), fracture of lower end of left ulna (a long bone in the forearm), and generalized muscle weakness. During an observation on 05/24/2021 at 9:13 a.m., observed socks, food particles, and trash items, including soiled gauze on the floor of Resident 119's room located in yellow zone. During a concurrent interview with Licensed Vocational Nurse 5 (LVN 5) stated the trash and other items should not be on the floor because of infection control. 11. A review of the Facesheet indicated the facility admitted Resident 121 on 05/9/2021, with diagnoses including chronic obstructive pulmonary disease (COPD - a long-term lung disease that blocks airflow and makes it difficult to breathe), hypertensive heart disease, nicotine dependence, and malignant neoplasm a cancerous tumor, an abnormal growth that can grow uncontrolled and spread to other parts of the body) of bronchus or lung. 12. A review of the Facesheet indicated the facility admitted Resident 122 on 05/14/2021, with diagnoses including asthma, COPD, diabetes mellitus with diabetic chronic kidney disease, and seizures. 13. A review of the Facesheet indicated the facility admitted Resident 123 on 05/13/2021 with diagnoses including respiratory failure, hypertensive heart disease, sepsis due to streptococcus pneumoniae (bacterial infections that can affect the lungs and other organs), and COPD. A review of the Facesheet (Admission Record) indicated the facility admitted Resident 124 on 05/12/2021 with diagnoses including fracture of one rib, left side, fracture of mandible (the jaw or jawbone), contusion (blood or bleeding under the skin due to trauma of any kind) of lung, and major depressive disorder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation with LVN 8 on 05/25/2021 at 6:21 a.m., CNA 8 did not wear a face shield when providing care to Residents 123 and 124 in the yellow zone. During a concurrent observation, LVN 8 provide CNA 8 with a face shield and informed CNA 8 to donn the face shield while working with Residents 123 and 124 in the yellow zone. During a concurrent interview, IP stated CNA 8 should always be wearing a face shield at all times in yellow zone for infection control. 14. A review of the Resident 125's H&P dated 05/12/2021, indicated diagnoses for Resident 125 included obesity (a disorder involving excessive body fat that increases the risk of health problems), coronary artery disease (CAD - damage or disease in the heart's major blood vessels), cardiomyopathy (a disease of the heart muscle that makes it harder for your heart to pump blood to the rest of your body) with Automatic Implantable Cardioverter Defibrillator (AICD - a device that monitors a person's heart rate), and generalized muscle weakness. 15. During an observation with Assistant Director of Nursing (ADON), on 05/27/2021, at 5:23 p.m., yellow zone Resident 126 was talking to AA in the green zone dining room area while AA was eating. During a concurrent interview, ADON stated yellow zone Resident 126 should not be in the green zone dining room area speaking to AA when AA is eating for infection control. 16. A review of the Facesheet indicated the facility admitted Resident 127 on 05/16/2021, with diagnoses including seizures (uncontrolled electrical activity in the brain, which may produce a physical convulsion), encephalopathy (damage or disease that affects the brain), and thrombocytopenia (when a person does not have enough platelets, cells in your blood that stick together to help it clot). 17. A review of the Facesheet indicated the facility admitted Resident 128 on 05/8/2021, with diagnoses including asthma, COPD, hypertensive heart disease with heart failure, and cellulitis (a common and potentially serious bacterial skin infection) of lower limb. 18. A review of the Facesheet indicated the facility admitted Resident 129 on 05/21/2021, for short term skilled rehabilitation and nursing care. A review of undated History and Physical, indicated Resident 129 diagnosis included seizures. 19. A review of the Facesheet, indicated the facility admitted Resident 132 on 05/17/2021, with diagnoses including diabetes mellitus (high levels of sugar in the blood), hypertensive (pertaining to high blood pressure) heart disease with heart failure, anemia (a condition in which you lack enough healthy red blood cells to carry adequate oxygen to your body's tissues), and generalized muscle weakness. 20. A review of the Facesheet indicated the facility admitted Resident 130 on 05/19/2021, with diagnoses including lateral malleolus (a bony projection with a shape likened to a hammer head, especially each of those on either side of the ankle) fracture of left fibula (the outer and usually smaller of the two bones between the knee and ankle), generalized muscle weakness, and nicotine dependence, cigarettes. During an observation on 05/24/2021 at 10:18 a.m., Infection Preventionist Nurse (IP) did not perform hand hygiene prior to donning isolation gown and gloves to assist Resident 130 in the yellow zone to the restroom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/24/2021 at 10:20 a.m. IP stated she did not hand sanitize prior to donning isolation gown or gloves to assist Resident 130. IP further stated she should have performed hand hygiene prior to donning isolation gown and gloves because of infection control. 21. A review of the Facesheet indicated the facility admitted Resident 131 on 05/11/2021, with diagnoses including aphasia (a language disorder that affects a person's ability to communicate after a stroke (damage to the brain from interruption of its blood supply) or head injury), cerebral infarction (also known as stroke), and hypertensive heart disease. 22. A review of the Facesheet indicated the facility admitted Resident 133 on 05/21/2021, with diagnoses including enterocolitis due to clostridium difficile (also called C. difficile, is bacteria that can cause swelling and irritation of the large intestine, or colon), urinary tract infection, anemia, hypertensive heart disease, and chronic (long-term) kidney disease). During an observation on 05/24/2021 at 10:14 a.m., Medical Doctor 1 (MD 1) donned isolation gown in the hallway outside Resident 133's room in the yellow zone. MD 1 did not tie the isolation gown at the waist, did not perform hand hygiene, donned clean gloves, walked to medication cart to speak with LVN 5 at medication cart located in the yellow zone hallway. MD 1's isolation gown touched the medication cart when speaking to LVN 5. MD 1 touching her glasses, touched the facility's census (an official count of the residents in the facility) form, and checked her phone with donned gloves. At 10:17 a.m., MD 1 turned and entered the room to assess Residents 125 and 132 in the yellow zone. introduced herself as MD 1. During an observation on 05/24/2021 at 10:31 a.m., observed MD 1 donned isolation gown without tying the gown, donned gloves without hand hygiene and entered Resident 133's yellow zone room. (What did MD 1 do in the room?) During an observation on 05/24/2021 at 12:40 p.m., MD 1 donned gown and gloves without performing hand hygiene or tying her isolation gown at the waist and entered Resident 124's yellow zone room to work with Resident 124. Observed no hand sanitizer in the room. During an observation with Housekeeper 1 (HK 1) on 05/24/2021 at 2:34, p.m., Residents 130 and 131, both entered Residents 121 and 122's room in the yellow zone, and stated they were going to smoke the on patio. During an interview on 05/24/2021 at 2:35 p.m., confirmed and stated observation of Residents 130 and 131 entered Resident 121 and 122's yellow zone to go smoke on the patio. HK 1 further stated Resident 121 and 122 should not go through each other's rooms to the smoking patio because of infection control. During an observation on 05/24/2021 at 4:27 p.m., Residents 4, 121, 122, 129, 130, and 131 from the yellow zone, and Residents 32 and 34 from the green zone were smoking cigarettes together unsupervised, sharing lighters, not social distancing, and passing cigarettes among each other. During an interview on 05/24/2021, at 4:29 p.m., the Director of Staff Development/Infection Preventionist Nurse (DSD/IP) stated yellow zone residents should not be going through each other's rooms to get through to the patio area to smoke for infection control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055060	A. Building B. Wing	06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Post Acute Care	12121 Santa Monica Boulevard Los Angeles, CA 90025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation with the DSD/IP, on 05/24/2021 at 4:30 p.m., Residents 4, 121, 122, 129, 130, and 131 from the yellow zone, and residents 32 and 34 from the green zone were smoking cigarettes together on the patio unsupervised. Concurrently, there was no signage posted for designated yellow zone or green zones noted on the patio. Concurrently, at 4:33 p.m., Resident 4 give from the yellow zone, gave a cigarette to Resident 34 from the green zone his cigarette. The DSD/IP informed Residents 4, 32, 34, 121, 122, 129, 130, 131 from the yellow zone, they must not smoke together for their safety and for infection control. The DSD/IP further stated yellow zone residents should smoke separately from the residents from the green zone, should not share cigarettes and or lighters, and should be supervised on the patio for safety and infection control. During an interview on 05/25/2021, at 8:47 a.m., Licensed Vocational Nurse/ Minimum Data Set Nurse (LVN/MDS) stated yellow zone residents, including Residents 130 and 131 should not be going through each other's rooms to get to the smoking patio for infection control. A review of the facility's policy and procedures titled Infection Control, revised date, 01/2012, indicated to provide infection control policies and procedures required for a safe and sanitary environment. The facility's infection control policies and procedures are intended to facility maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. The facility's infection control policies and procedures apply equally to all facility staff consultants, contractors, residents . A review of the facility's policy and procedures titled COVID-19 (Coronavirus Disease 2019), revised date, 03/26/2021, indicated the facility's policy is to follow the California Department of Public Health (CDPH), Centers for Disease Control and Prevention (CDC) and/or local health department (LHD) guidelines in the recognition and management of COVID-19. The most recent guidance from the CDC, All Facilities Letters (CDPH) and LHD directives will be used for any practices not outlined in this document. Diligent hand hygiene practices are an important step in prevention and Alcohol-based hand rubs (i.e., hand sanitizer) should be used between hand washing). Wearing the appropriate face masks and coverings for the situation. Strict adherence to screening, hand hygiene, cough etiquette and personal protective equipment (PPE) shall be followed. Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2 (COVID-19). A review of Centers for Disease Control and Prevention (CDC) document titled Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 dated 03/30/2020, included PPE must: a. Be donned correctly before entering the resident area (e.g., isolation room, unit if cohorting) b. Performing hand hygiene using hand sanitizer c. Put on NIOSH-approved N95 filtering mask facepiece respirator d. Put on face shield or goggles e. Perform hand hygiene before putting on gloves f. Put on isolation gown. Tie all ties on the gown (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	g. Remain in place and be worn correctly for the duration of work in potentially contaminated areas h. Not be adjusted (e.g., retying gown, adjusting respirator/facemask) during patient care.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40541 Based on interview and record review, the facility failed to administer the pneumococcal (bacterial infections that can affect the lungs and other parts of the body) vaccine (a biological substance designed to protect humans from infections caused by bacteria and viruses) as appropriate for three of five sampled residents (Residents 17, 30, and 61). This deficient practice placed the residents at risk to not attain or maintain their highest practical level of physical, mental and psychosocial well-being. Findings: A review of Resident 17's Facesheet (Admission Record) indicated Resident 17 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus (high levels of sugars in the blood), and major depressive disorder. During an interview and a concurrent record review of Resident 17's clinical record on 5/28/2021, at 1:33 p.m. , the Infection Preventionist Nurse (IP) stated Resident 17 consented for the pneumococcal vaccine, as indicated on the signed pneumococcal vaccination, informed consent or refusal form dated 10/5/2020. The IP further stated no record was found in Resident 17's clinical record of the pneumococcal vaccine being offered or administered at that time. The IP further stated the pneumococcal vaccine should have been offered or administered timely, and the refusal or administration of the pneumococcal vaccine should have been documented to prevent pneumococcal infections. A review of Resident 30's Facesheet indicated Resident 30 was readmitted to the facility on [DATE] with diagnoses including diabetes mellitus, heart failure, and hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) following cerebral infarction (also known as a stroke- damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side. During an interview and concurrent record review of Resident 30's clinical record on 5/28/2021, at 1:47 p.m., the IP stated no record of pneumococcal vaccine consent or refusal or administration of the pneumococcal vaccine found in Resident 30's clinical record in 10/2020 when Resident 30 was offered the influenza vaccine. The IP further stated the pneumococcal vaccine should have been offered or administered to Resident 30 in 10/2020 when the influenza vaccine was offered to Resident 30. IP further stated the pneumococcal vaccine should have been offered or administered timely, and the refusal or administration of the pneumococcal vaccine should have been documented to prevent pneumococcal infections. A review of Resident 61's Facesheet indicated Resident 61 was readmitted to the facility on [DATE] with diagnoses including dislocations or right hip, dislocation of internal right hip prosthesis (an artificial body part, such as a leg), and anemia (a condition when there are not enough healthy red blood cells to carry oxygen to your body's organs). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review of Resident 61's clinical record with the IP, on 5/28/2021, at 1:54 p.m., the IP stated Resident 61 consented for the pneumococcal vaccine, as indicated on the signed pneumococcal vaccination, informed consent or refusal form dated 10/5/2020. IP further stated no record was found in Resident 61's clinical record of the pneumococcal vaccine being offered or administered at that time. The IP further stated the pneumococcal vaccine should have been offered or administered timely, and the refusal or administration of the pneumococcal vaccine should have been documented to prevent pneumococcal infections. A review of the facility's policy and procedures titled Pneumococcal Disease Prevention, revised date 2/28/2021, indicated, to minimize the risk of residents acquiring, transmitting or experiencing complications from pneumococcal disease. The facility will offer pneumococcal immunizations to each resident, according to Centers for Disease Control and Prevention (CDC) recommendations, unless it is medically contraindicated or the resident has already been immunized. Documentation . the resident's medical record shall include documentation that indicates, at a minimum, the following: . a completed copy of IC-20-Form B - Pneumococcal Vaccination, Informed Consent or Refusal placed in the resident's medical record. Whether the resident received the Pneumococcal Conjugate Vaccine (PCV13) or the (Pneumococcal Polysaccharide Vaccine (PPSV23) vaccine, or did not receive whether because of medication contraindications or refusal.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43243 Based on observation and record review, the facility failed to provide at least 80 square feet (sq. ft.) per resident in multiple resident bedrooms for two of 34 resident rooms (rooms [ROOM NUMBERS]). The two rooms each hold 4 beds. Findings: During the general observation of room [ROOM NUMBER] and room [ROOM NUMBER], on 5/24/2021, the residents were observed to have ample space to move freely inside the rooms, and there was sufficient space to provide freedom of movement for the residents and for nursing staff to provide care to the residents and space for beds, side tables, and resident care equipment. A review of the Room Size Waiver request letter, dated 5/24/2021, submitted by the Administrator for two rooms, indicated there was enough space to provide for each resident's care, dignity, and privacy. The letter also indicated that the rooms were in accordance with the special needs of the residents and would not have an adverse effect on the residents' health and safety or impede the ability of any resident in the rooms to attain or maintain his or her highest practicable well-being. The following rooms provided less than 80 square feet per resident: Rooms # Beds Sq. Ft. Sq. Ft/Bed 106 4 304 76 204 4 304 76 The minimum square footage for a 4-bed room is 320 sq. ft. The facility submitted a written request for continued waiver. The room waiver was recommended to continue and is contingent with federal regulations at accommodation of needs (483.15 e) and Resident Rights (483.10).