STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055253	A. Building B. Wing	06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. John of God Retirement	2468 South St Andrews Place Los Angeles, CA 90018

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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 - Some	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** 30840 Based on observation, interview, and record review, the facility failed to maintain two residents' dignity during dining (Residents 22 and 77). Certified Nurse Assistant 20 (CNA 20) was observed standing over Resident 22 while feeding the resident in the dining room, and CNA 20 was also observed standing over Resident 77 while feeding the resident inside Resident 77's room. This deficient practice violated Residents 22 and 77 rights to treated with respect and dignity. Findings: a. During an observation on 5/25/2021 at 12:30 p.m., Certified Nurse Assistant 20 (CNA 20) was observed standing over Resident 22 feeding the resident by mouth after setting up the resident's lunch tray in the dining room. During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22's diagnoses included muscle weakness, dysphagia (difficulty swallowing), and major depression. During a review of Resident 22's Minimum Data Set (MDS), a standardized assessment and screening tool, dated 3/1/2021, the MDS indicated Resident 22's sometimes had the ability to make decisions of daily living. The MDS indicated Resident 22 required extensive assistance from nursing staff members with activity of daily livings ([ADLs] self-care activities performed on a daily basis, such as turning, feeding, and toilet use). The care area assessment (CAA) of the MDS indicated Resident 22 triggered under nutrition status as requiring staff to physically assist the resident with feeding. During a review of Resident 22's physician's order dated 1/2/2021, the physician's order indicated regular diet pureed texture, nectar thick with consistency three times a day. During a review of Resident 22's care plan dated 6/17/2021, the care plan indicated a dietary focus with a goal for safety and interventions that included respect when feeding Resident 22. During an interview on 5/25/2021 at 12:35 p.m. with CNA 20, CNA 20 stated it was a dignity issue to stand over a resident while feeding the resident. b. During an observation on 5/25/2021 at 12:45 p.m., CNA 20 was observed standing while feeding Resident 77 in bed. (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 - Some	During a review of Resident 77's Admission Record, the Admission Record indicated Resident 77's diagnoses included muscle weakness, dysphagia, and cardiomegaly (disease heart). During a review of Resident 77's MDS dated [DATE], the MDS indicated Resident 77 sometimes had the ability to make decisions of daily living. The MDS indicated Resident 77 required limited to extensive assistance from staff ADLs. The CAA of the MDS indicated Resident 77 triggered under nutrition status as requiring staff to physically assist the resident with feeding. During a review of Resident 77's physician's dietary order dated 8/1/2019, the physician's dietary order indicated regular diet mechanically soft/ground texture with no restrictions. During a review of Resident 77's care plan dated 8/1/2019, the care plan indicated a dietary concern with nutritional risk due to dysphagia. The goal indicated for Resident 77 to tolerate feeding, and staff's interventions included appropriate assisting with feeding. During an interview on 5/25/2021 at 12:50 p.m., CNA 20 stated it was inappropriate to stand over the residents while feeding the residents. During an interview on 5/25/2021 at 12:55 p.m. with LVN 30, LVN 30 stated the nurses have had in-services regarding not standing over residents when feeding the residents. During an interview on 6/1/2021 at 8:40 a.m. with LVN 30, LVN 30 stated the care plan intervention should include no standing over residents while feeding by mouth to remind the nurses of maintaining residents' dignity when feeding residents.

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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 0552 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview and record review, the facility failed to obtain informed consent for mittens and a self release belt for two of two sampled residents (42 and 102). This had the potential for the residents and/or the responsible party not being aware of the risks and benefits of the proposed care. Findings: a. During a tour, Resident 42 was observed with a self release belt around her waist. The resident was observed not able to release the belt. During a review of Resident 42's Admission Record, the Admission Record indicated Resident 42 was admitted to the facility on [DATE]. Resident 42's diagnoses included unspecified dementia with behavioral disturbance (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), heart failure (condition in which the heart cannot pump enough blood to meet the body's needs), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning). During a review of Resident 42's MDS, a standardized assessment and care screening tool, dated 3/19/2021, the MDS indicated Resident 42 had a short term and long-term memory problem. The MDS indicated under section P (restraints and alarms) that daily use of trunk restraint while out of bed or used in chair. However, there was no consent signed by the residents representative. b. During a review of Resident 102's Face Sheet (admission record), the Face Sheet indicated Resident 102 was admitted to the facility on [DATE]. Resident 102's diagnoses included lack of coordination (inability to coordinate bodily movements, especially movements of the muscles), dysphagia (difficulty of swallowing), type 2 diabetes mellitus (high blood sugar), unspecified psychosis (a mental disorder characterized by a disconnection from reality) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 102's MDS, dated [DATE], the MDS indicated Resident 102 had severe cognitive function (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a concurrent interview and record review of the physician orders on 7/30/2021 at 9:00 AM, registered nurse 1 (RN1) stated and confirmed Resident 42 and 102 had physician orders for the use of restraints (physical measure used to control the physical behavior of a resident). Per RN 1, according to the physician orders, the physician received informed consent from the responsible party through telephone order only for resident 42 and 102. Per RN 1, there were no written documentation made by the physician that the physician received informed consent from the responsible parties. (continued on next page)

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F 0552 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview and record review with quality management coordinator (QM)on 7/30/2021 at 12:00 PM, the QM stated that the facility does not have a written consent form. Per QM, when the facility switched to electronic charting from paper charting the facility removed written documentation of informed consent. Per QM, upon receipt of the physician order for restraints, the physician verbally confirmed that the physician received informed consent from the responsible parties. The nurses then documented on the order that the physician received informed consent from the responsible party. Per QM, the physician for Resident 42 and 102 had no physician documentation to confirm the physician received informed consent and explained the nature, risk, and benefits of the application of restraints. During an interview with the director of nursing (DON) and the administrator (Admin) ,on 7/30/2021 at 12:00 PM, the DON and the admin confirmed that the physician for Resident 42 and 102 had no documentation on the medical records to prove that the physician, at a minimum, explained the nature, risks and benefits of restraint use to the responsible parties prior to prescribing the use of restraints for Resident 42 and 102. A review of policy and procedure(p/p) titled Use of Restraint revised date 04/2017 indicated, residents and or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use. A review of P/P titled Informed Consent revised April 2017 indicated, the resident's consent and notification or lack of notification shall be documented in the Resident's health record.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44088 Based on observation, interview, and record review, the facility failed to ensure resident call lights was within easy reach to enable residents to call for assistance with activities of daily living ([ADLs] daily self-care activities) and ensure the patio door lock leading into the resident's room was functioning for three of three sampled residents (Residents 29, 64, and 82). This deficient practice could potentially cause Residents 29 and 64 to feel frustrated and neglected, a decreased independent functioning, and could potentially result in falls, injuries, pain, and skin breakdown, and caused Resident 82 to feel unsafe and lose sleep at night. Findings: a. During an observation and concurrent interview on 5/25/21 at 10:30 a.m. with Resident 64, Resident 64 was observed lying in bed. Resident 64 had an adaptive call light laying on the right side of the bed at head level. Resident 64 stated she was unable to press the call light because it was too far. Resident 64 attempted press the call light using the left hand but was unable to reach the call light. Resident 64 stated she would not be able to call for help in case of an emergency if she needed pain medication and had to wait for staff to clean her. During an observation and concurrent interview on 5/25/21 at 10:30 a.m. with Certified Nurse Assistant 6 (CNA 6), CNA 6 stated the adaptive call light was not positioned correctly when staff pulled Resident 64 up on the bed. CNA 6 stated Resident 64's call light was not positioned where the resident could reach and press the call light. CNA 6 repositioned the adaptive call light on the resident's abdomen where she could press for assistance. During a review of Resident 64's Admission Records, the Admissions Records indicated Resident 64 was admitted to the facility on [DATE]. Resident 64's diagnoses included Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills), unspecified osteoarthritis (degenerative joint disease), and essential hypertension (high blood pressure). During a review of Resident 64's Minimum Data Set (MDS), resident assessment and care-screening tool, dated 4/09/2021, the MDS indicated Resident 64 had no cognitive (thought process) impairment for daily decision making. The MDS indicated Resident 64 required extensive assistance for mobility, transfer, dressing, toilet use and personal hygiene and required supervision when eating. b. During an observation and concurrent interview on 5/25/21 at 11:05 a.m. with Resident 29, Resident 29 was observed sitting in a wheelchair. Resident 29's call light was observed tied on the bed, located at the back of the resident. Resident 29 stated he was unable to locate his call light because it was too far. Resident 29 stated he would not be able to call for help in case of an emergency and had to wait for staff to clean him. Resident 29 stated staff usually positioned his call light at the side of his wheelchair, so it was easily accessible. Resident 29 stated if he cannot locate his call light, he feels unhappy and frustrated. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview on 5/27/2021 at 8:14 a.m. with Resident 29 and CNA 8, Resident 29 was observed sitting in a wheelchair. Resident 29 stated he was unable to locate his call light. CNA 8 stated Resident 29's call light was on the floor and it should be within the resident's reach. CNA 8 stated Resident 29 would not be able to call for assistance in case of an emergency and when he needed assistance for activities of daily living ([ADLs] daily self-care activities). During a review of Resident 29's Admission Records, the Admission Records indicated Resident 29 was admitted to the facility on [DATE]. Resident 29's diagnoses included hemiplegia (inability to move one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (damage to the brain from interruption of its blood supply), and abnormalities of gait (a person's manner of walking) and mobility (the ability to move). During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29 had no cognitive impairment for daily decision making. The MDS indicated Resident 29 required extensive assistance for mobility, transfer, dressing, toilet use and personal hygiene and limited assistance when eating. During an interview on 6/1/2021 at 12:20 p.m. with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated all staff were responsible in positioning the resident's call lights and the call light should be within reach. LVN 7 stated Resident 29 would not be able to call for help in case of an emergency, request pain medications, and for repositioning as needed. During an interview on 6/1/21 at 3:29 p.m. with the Director of Nursing (DON), the DON stated the call light should be positioned at reasonable reach of the resident and was the responsibility of all staff. The DON stated residents would feel frustrated and could cause untoward findings to their ADL's if they cannot locate their call light. During a review of the facility's policy and procedure (P/P) titled, Call lights and use of the cold cord system, dated 8/2017, the P/P indicated the call lights should be within resident's reach when in their room or on the toilet. c. During a review of Resident 82's Admission Record (Face sheet), the Admission Record indicated Resident 82 was admitted to the facility on [DATE]. Resident 82's diagnoses included transient ischemia attack (when blood flow to the brain is blocked for a short amount of time), and diabetes mellitus (high blood sugar). During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82 had no cognition (ability to make decisions, understand and learn) impairment. During a review of Resident 82's Activity assessment dated [DATE], the Activity Assessment indicated that it was very important for Resident 82 to have a place to lock and keep his things safe. During an interview on 5/25/2021 at 1:03 p.m. with Resident 82, Resident 82 stated the patio door in the resident's room did not lock. Resident 82 stated the facility was notified on the day of the resident's admission. Resident 82 stated the patio door not being able to lock was scary and caused him to lose sleep at night. Resident 82 stated he used his walker to secure the patio door at night. Resident 82 stated maintenance came in to look at the door and stated the door could not be fixed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/27/2021 at 8:45 a.m. with Resident 82 and the Maintenance Director (MD), Resident 82 stated the patio door was checked and reiterated the MD stated the door could not be fixed. During an observation on 5/27/2021 at 8:49 a.m., the MD attempted to close the patio door after three attempts with success. In an unsuccessful attempt, Resident 82 attempted to lock the door, the MD was able to walk directly in the room from the patio. During an interview on 5/27/2021 at 8:55 a.m. with the MD, the MD stated the door could be fixed and that it would take approximately one week to receive the part that the door requires. When requested, the MD could not locate the work order for the door lock for Resident 82's patio door. During an interview on 5/27/2021 at 8:58 a.m. with Resident 82, Resident 82 stated he felt unsafe and his doors in his home are always locked. Resident 82 stated, I am on the 2nd floor, but this is still scary. During a review of the facility's revised P/P, dated 4/2017 and titled Maintenance Service, the P/P indicated it is the facility's policy to provide maintenance services to all areas of the building, grounds and equipment establishing priorities in providing repair services maintaining work order requests. The P/P indicated maintenance service is to assure that the building, grounds and equipment are kept in a safe and operable manner.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on interview and record review, the facility failed to provide two of six residents (Residents 45 and 48) and/or their responsible parties with written information on how to formulate an Advanced Directive (a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor). This deficient practice had the potential for violating Residents 45 and 48 choices about their medical care. Findings: During a review of Residents 45 and 48's medical records, the medical records indicated the following information was missing: Resident 45, who was admitted to the facility on [DATE] and readmitted on [DATE], did not have an advanced directive or a signature declining information on how to obtain an advanced directive. Resident 48, who was admitted on [DATE] and readmitted on [DATE], did not have an advanced directive or a signature declining information on how to obtain an advanced directive. During a record review of Residents 45 and 48's charts on 5/26/2021 at 10:36 a.m., the chart indicated there was no advance directive form. During an interview and concurrent record review on 5/27/2021 at 9:59 a.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated once residents are admitted to the facility, the advance directive form should be in the chart right away. LVN 2 stated if we cannot find the advance directive form for Residents 45 and 48 in the chart then we do not have it. During a concurrent interview and record review on 5/27/2021 at 10:05 a.m. with the Social Services Director (SSD), the SSD stated that securing the advance directive form was her primary responsibility and it should be in the resident chart upon admission. The SSD stated it was offered in the past but she does not have any reason why it was not done and even if the resident was readmitted , it should have been in the resident's chart. During a review of the facility's policy and procedure (P/P) titled, Advance Directives, revised on 4/2017, the P/P indicated Advance directives will be respected in accordance with state law and facility policy. 1. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Each resident will also be informed that our facility's policies do not condition the provision of care or discriminate against an individual based on whether or not the individual has executed an advance directive. 3. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives. 4. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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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** 30840 Based on observation, interview, and record review, the facility failed to: 1. Maintain the shower room in a clean and sanitary manner. 2. Ensure the Shower Cleaning Log as well as the Lift Cleaning Checklist was completed. 3. Ensure the shower room door was kept locked for resident safety. These deficient practices had the potential to expose 20 out of 20 residents to an infection and injury on [NAME].Pascal unit. Findings: a. During the initial tour of the [NAME]. Pascal unit on 5/23/2021 at 10:30 a.m. in the presence of House Keeper 30 (HK 30), the shower room's cleaning log did not have signatures to indicate when the shower room was last cleaned from 5/23/2021 to 5/25/2021. Observed an empty bottle of shaving cream 1.5 ounces (oz) and moisturizing body lotion 4 oz. inside the shower room, on top of a small trash can. During an interview on 5/23/2021 at 10:30 a.m. with HK 30, HK 30 stated when the shower room has been cleaned, staff were supposed to sign the log sheets. During an interview on 6/1/2021 at 8:26 a.m. Housekeeping Supervisor (Supervisor 50), Supervisor 50 stated housekeeping staff was supposed to sign the log record for the shower room and Lift [NAME] (use for resident with assisting for nurses to shower residents) after cleaning the shower but sometimes the housekeeper forgot to sign the log records. b. On 5/23/2021 at 10:35 a.m., during the initial tour observed the latch strike plate for the door lock stuffed with tissue paper preventing the entry door from locking. During an interview on 5/25/2021 at 10:30 a.m. with Maintenance 55, Maintenance 55 stated the entrance door into the shower was not broken, but the nurses put tissue paper into the latch strike preventing the door from being locked because the nurses do not want to keep asking for the key for the shower room. Maintenance 55 stated the entrance door was supposed to be locked for the residents' safety, so the residents could not go into the shower room alone and fall.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on observation, interview, and record review, the facility failed to ensure that residents had a specific medical symptom, physician's order, assessment, care plan and consent before the use of physical restraints for three of eight sampled residents (Residents 42 ,99, and 102). This deficient practice had the potential for the residents to have reduced independence, functional capacity, and quality of life. Findings: a. During a review of Resident 42's Admission Record, the Admission Record indicated Resident 42 was admitted to the facility on [DATE]. Resident 42's diagnoses included unspecified dementia with behavioral disturbance (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), heart failure (condition in which the heart can not pump enough blood to meet the body's needs), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning). During a review of Resident 42's Physician's order, for the month of May, with the Minimum Data Set (MDS) coordinator (MDS Coordinator 1), MDS Coordinator 1 confirmed that there was an order for an abdominal binder to prevent Resident 42 from pulling out the gastrostomy ([G-tube] surgical opening into the stomach for nutrition, hydration, and medication) tube dated 5/13/2020. The MDS Coordinator 1 was unable to verify if there was a physician's order of a soft belt nor any documentation in the medical chart that a restraint soft belt was obtained. During a review of Resident 42's MDS, a standardized assessment and care screening tool, dated 3/19/2021, the MDS indicated Resident 42 had a short term and long-term memory problem. The MDS indicated under section P (restraints and alarms) that daily use of trunk restraint while out of bed or used in chair. During an observation on 5/25/2021 at 10:53 a.m., Resident 42 was observed with a soft belt while up in the wheelchair attached on the side of her wheelchair. Resident 42 was unable to remove the soft belt when instructed to do so. Resident 42 was non- communicative during this time. During an observation, interview, and concurrent record review on 5/26/2021 at 9:14 a.m. with Licensed Vocational Nurse 11 (LVN 11) and Resident 42, LVN 11 stated Resident 42 was usually French-speaking and knew a little bit of English when asked if Resident 42 was able to communicate her needs. LVN 11 stated nurses made rounds to check if residents needed help. Resident 42 was observed wearing a seatbelt restraint. LVN 11 stated she could not find the physician's order for the seatbelt, but stated Resident 42 had an order for an abdominal binder. During an interview on 5/26/21 at 8:35 a.m. with MDS Coordinator 1, MDS Coordinator 1 stated Resident 42 was on restraint for abdominal binder but not waist or seatbelt restraint. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. John of God Retirement	2468 South St Andrews Place Los Angeles, CA 90018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P/P) titled, Use of Restraint, revised 4/2017, the P/P indicated restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. The P/P indicated restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. b. During a review of Resident 99's Admission Record (Face Sheet), the Face Sheet indicated Resident 99 was admitted to the facility on [DATE]. Resident 99's diagnoses included dementia without behavioral disturbance, hypothyroidism (condition in which your thyroid gland doesn't produce enough of certain crucial hormones), acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity (condition that occurs when a blood clot forms in a vein located deep inside your body). During a review of Resident 99's MDS, dated [DATE], the MDS indicated Resident 99 rarely/never understands and rarely/never understood. The MDS indicated Resident 99 required extensive to total assistance with activities of daily living ([ADLs] tasks of everyday life, include eating, dressing, getting into or out of a bed or chair, taking a bath or shower and using the toilet). During an observation on 5/25/2021 at 11:18 a.m., Resident 99 was observed in bed with two full siderails up. During an interview and concurrent record review on 5/26/21 at 8:25 a.m. with MDS Coordinator 1 and MDS Coordinator 2, MDS Coordinators 1 and 2 stated Resident 99's physician's order indicated to use low bed with two-quarter siderails. Resident 99's informed consent was signed by the resident's Responsible Party (RP 2) for one-fourth siderails to prevent the resident from rolling out of the bed. During an interview on 5/26/2021 with Registered Nurse 1 (RN 1) and MDS Coordinators 1 and 2, RN 1 and MDS Coordinators 1 and 2 stated the resident's siderails assessment should be completed upon admission and during the quarterly assessment and annually thereafter. During a review of the facility's P/P titled, Proper use of Siderails, revised dated 4/2017, the P/P indicated side rails were considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). c. During a review of Resident 102's Face Sheet (admission record), the Face Sheet indicated Resident 102 was admitted to the facility on [DATE]. Resident 102's diagnoses included lack of coordination (inability to coordinate bodily movements, especially movements of the muscles), dysphagia (difficulty of swallowing), type 2 diabetes mellitus (high blood sugar), unspecified psychosis (a mental disorder characterized by a disconnection from reality) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 102 had severe cognitive function (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During an observation on 5/25/2021 at 11:43 a.m., Resident 102 was observed with mittens on both hands and both siderails in the up position. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/26/2021 at 7:52 a.m., Resident 102 was observed with mittens on both hands and both siderails in the up position. During an observation and concurrent interview with Certified Nursing Assistant 9 (CNA 9) and LVN 3 on 5/26/2021 at 9:36 a.m., Resident 102 was observed with mittens on both hands and both siderails in the up position. CNA 9 stated Resident 102 hit the staff and it does not hurt as much and you don't feel the force as much with the mittens on. LVN 3 stated Resident 102 was pulling at the G-tube and that was why Resident 102 was wearing hand mittens on both hands. During a concurrent interview and record review on 5/26/2021 at 1:49 p.m., LVN 2 confirmed that the consent form found in Resident 102's chart was empty. During a concurrent interview and record review on 5/26/2021 at 1:55 p.m., RN 1 stated whoever called Resident 102's physician and informed the resident's family should have followed up the consent form or at least endorsed it to the next shift to be followed up. RN 1 stated he did not have an explanation why the written consent form was empty. During a concurrent interview and record review on 5/27/2021 at 10:49 a.m. with LVN 2, LVN 2 stated the reason for restraints should be written on the change of condition (COC) form regarding Resident 102's behavior and why the restraints were needed and written in the assessment. LVN 2 indicated there was no care plan for the use of hand mittens and no documentation the least restrictive measures were implemented prior to the use of the hand mittens. LVN 2 stated that least restrictive measures should be used first before physical restraints. During the review of the facility's P/P titled, Promoting/Maintaining Resident Dignity, revised 4/2017, indicated restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. The P/P indicated restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. 3. Examples of devices that are/may be considered physical restraints include: leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove. 4. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43906

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview, and record review, the facility failed to ensure there was an accurate assessment, care plan and consent before the use of physical restraints for two of eight sampled residents (Residents 42 and 99). This deficient practice had the potential for the residents to have reduced independence. Findings: During a review of Resident 42's Admission Record, the Admission Record indicated Resident 42 was admitted to the facility on [DATE]. Resident 42's diagnoses included unspecified dementia with behavioral disturbance (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), heart failure (condition in which the heart can not pump enough blood to meet the body's needs), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning). During a review of Resident 42's physician's order, for the month of May 2021, with the MDS Coordinator 1, MDS Coordinator 1 confirmed there was an order for an abdominal binder to prevent the resident from pulling out the gastrostomy ([G-tube] surgical opening in the stomach for nutrition, hydration, and medication) tube, dated 5/13/2020. MDS Coordinator 1 was unable to verify there was a physician's order of a soft belt nor any documentation in the medical chart that a consent for a soft belt restraint was obtained. During a review of Resident 42's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 3/19/2021, the MDS indicated Resident 42 had a short-term and long-term memory problem. The MDS indicated under Section P (restraints and alarms), the use of a trunk restraint was coded daily while out of bed or used while in the chair. During an observation on 5/25/2021 at 10:53 a.m., Resident 42 was observed with a soft belt while up in the wheelchair attached on the side of the wheelchair. Resident 42 was unable to remove the soft belt when instructed to do so. Resident 42 was non- communicative during this time. During an observation, interview and concurrent record review on 5/26/2021 at 9:14 a.m. with Licensed Vocational Nurse 11 (LVN 11), LVN 11 stated Resident 42 was French-speaking and knew a little bit of English. LVN 11 confirmed Residents 42's seatbelt restraint while the resident was observed up in a wheelchair. LVN 11 could not find the physician's order for the seatbelt, but LVN 11 stated Resident 42 had an order for an abdominal binder. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 99's admission record (Face Sheet), the admission record indicated Resident 99 was admitted to the facility on [DATE]. Resident 99's diagnoses included dementia without behavioral disturbance, hypothyroidism unspecified (condition in which your thyroid gland doesn't produce enough of certain crucial hormones), and acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity (condition that occurs when a blood clot forms in a vein located deep inside your body). During a review of Resident 99's MDS, dated [DATE], the MDS indicated Resident 99 rarely/never understands and rarely/never understood. The MDS indicated Resident 99 required extensive to total assistance with activities of daily living ([ADLs] tasks of everyday life, include eating, dressing, getting into or out of a bed or chair, taking a bath or shower and using the toilet). The MDS indicated under Section P (restraints and alarms) the use of siderails while in bed was not coded. During an observation on 5/25/2021 at 11:18 a.m., Resident 99 was observed in bed with two full siderails in the up position. During an interview and concurrent record review on 5/26/2021 at 8:25 a.m., with MDS Coordinators 1 and 2, MDS Coordinators 1 and 2 stated Resident 99's physician's order indicated to use a low bed with two-quarter siderails and one-fourth siderails to prevent the resident from rolling out the bed. Resident 99's informed consent was signed by the resident's Responsible Party (RP 2). During an interview on 5/26/2021 with Registered Nurse 1 (RN 1) and MDS Coordinators 1 and 2, RN 1 and MDS Coordinators 1 and 2 stated a siderails assessment should be done upon admission and during the quarterly assessment and annually thereafter. RN 1 and MDS Coordinators 1 and 2 verified Resident 99 and full siderails in the up position and stated they would ask maintenance to change the bed because it was considered a restraint. During a review of the facility's undated policy and procedure (P/P) titled, Use of Restraint, the P/P indicated prior to placing a resident in restraints, there shall be a pre-screening assessment and review to determine the need for restraints. The P/P indicated assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on interview and record review, the facility failed to ensure the Minimum Data Set ([MDS] resident assessment and care-screening tool) was accurately coded for one sampled residents (Resident 104) who was under hospice care (care provided for people in the final phase of a terminal illness and with a focus on comfort and quality of care). This deficient practice provided inaccurate resident information and had the potential to affect the residents' care. Findings: During a review of Resident 104's admission record (Face sheet), the admission record indicated the resident was admitted to the facility on [DATE]. Resident 104's diagnoses included encounter for palliative care (specialized medical care for people living with a serious illness), pneumonia (infection that inflames the air sacs in one or both lungs), diastolic congestive heart failure (occurs when your heart muscle does not pump blood as well as it should). During a review of Resident 104's Minimum Data Set (MDS), an assessment and care-screening tool, dated 2/12/2021, the MDS indicated Resident 104 was not on hospice care while in the facility. During a review of Resident 104's physician's order dated 2/12/2021, the physician's order indicated to admit Resident 104 to hospice under routine level of care. During an interview and concurrent review of Resident 104's MDS on 6/1/2021 at 8:45 a.m. with MDS Coordinator 2, MDS Coordinator 2 stated hospice care was not coded on the MDS and she would modify the section and resubmit. During a review of the facility policy and procedure (P/P) titled, Resident assessment and care planning, revised April 2017, the P/P indicated a resident assessment form is used to obtain information on the status of the resident's physical, mental and psychological function. The P/P indicated the assessment identifies risk factors associated with possible functional decline and the resident's objective for maintaining or improving functional abilities. The comprehensive assessment is completed with participation of appropriate health professionals.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43906 Based on observation, interview, and record review, the facility failed to develop and/or implement a person-centered care plan for two of 21 sampled residents (Residents 64 and 99). The facility failed to: 1. Implement Resident 64's care plan after the resident continued to have complaints of tooth pain. 2. Initiate/develop a care plan for the use of siderails for Resident 99. Resident 99 was restrained using two full siderails without a physician order, assessment and care plan. These deficient practices had the potential for lack of continuity of care, harm and/or injuries to Residents 64 and 99. Findings: a. During a review of Resident 64's Admission Record, the Admission Record indicated Resident 64 was admitted to the facility on [DATE]. Resident 64's diagnoses included Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills) , unspecified osteopathic (degenerative joint disease), and essential hypertension (high blood pressure). During a review of Resident 64's Minimum Data Set (MDS), assessment and care-planning tool, dated 4/9/2021, the MDS indicated Resident 64 had no cognitive (ability to learn remember, understand and decisions) impairment for daily decision making. The MDS indicated Resident 64 required extensive assistance on staff for mobility, transfer, dressing, toilet use and personal hygiene, and required supervision when eating. During a review of Resident 64's change in condition (COC) evaluation dated 12/14/2021, the COC evaluation indicated Resident 64 complained of tooth pain three out 10 on a pain scale (0 = no pain, 10= the worse possible pain). During review of Resident 64's care plan titled, At risk for oral/dental discomfort related to aging dentition, needs assists with oral dental hygiene, initiated on 1/29/2021, the care plan indicated the goal was for the resident to be free from signs of oral/dental discomfort daily, if possible, for 3 months. The staff's interventions included: 1. Dental consult if indicated and ordered. 2. Monitor tolerance of diet and alter texture as needed. 3. Oral surgeon to visit resident on 5/13/2021 in PM 4. Provide oral care after meals to remove leftover foods from mouth. 5. Report any signs of oral/dental pain, gum swelling/bleeding, or foul odor from mouth promptly. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 64's Medication Administration Records (MARs) from the month of December 2020 and January 2021, the MAR indicated Resident 64 received Benzocaine gel 20% for dental pain on 12/21/2020, 1/2/2021, and on 2/28/2021. During a review of Resident 64's MARs from the month of May 2021, the MARs indicated Resident 64 received Tramadol 50 milligram ([mg] unit of weight) everyday for complaints of pain level of 7 to 8 out of 10 on a pain scale. During a concurrent observation and interview with Resident 64 on 5/25/2021 at 10:30 a.m., Resident 64 was observed laying in bed with the head of the bed elevated. Resident 64 complained of lower front tooth pain. Resident 64 stated she gets Tramadol every eight hours, but had not received any at that time. Resident 64 stated she had been waiting for three months to have a dentist appointment, and has been eating soup and cottage cheese for the past three months. During a concurrent observation and interview with Resident 64 and Licensed Vocational Nurse 7 (LVN 7) on 5/26/2021 at 8:08 a.m., Resident 64 complained of pain to LVN 7. LVN 7 stated Resident 64 cannot have Tramadol because it was given at 5:51 a.m. on 5/26/2021. Resident 64 asked if she can have orajel, LVN 7 stated it was discontinued. LVN 7 stated she would contact Resident 64's physician to get an order for a stronger pain medication and orajel. During an interview on 5/26/2021 at 12:48 p.m. with Resident 64, Resident 64 stated her pain level was six out of ten. Resident 64 stated her pain medication was changed and she was given Tylenol with Codeine (pain reliever). LVN 7 stated she received an order from Resident 64's physician to start Tylenol with codeine every four hours. During a concurrent interview and record review on 5/28/2021 at 10:28 a.m., LVN 8 stated there was no care plan to address Resident 64's complaints of tooth pain. LVN 8 stated the care plan should have been updated when a change of condition was initiated in December 2020. LVN 8 stated the care plan provided tools to care for the resident. During an interview on 6/1/2021 at 12:20 p.m. with LVN 7, LVN 7 stated all licensed staff were responsible for updating care plans. LVN 7 stated Resident 64's care plan should have been updated when she complained of a tooth ache. LVN 7 stated an updated care plan was important to make sure the resident can receive the correct care and services. During an interview on 6/1/2021 at 1:33 p.m. with MDS Coordinator 2, MDS Coordinator 2 stated that licensed nurses were responsible for updating care plans. MDS Coordinator 2 stated she was responsible for completing the base line care plan upon admission, but it was the responsibility of the licensed nurse to initiate and update the care plan for any change of condition or new problems identified. MDS Coordinator 2 stated the care plan was a tool to assess, plan, implement and monitor the effectiveness of a resident's treatment plan. During an interview on 6/1/2021 at 3:29 p.m. with the Director of Nursing (DON), the DON stated for any acute changes identified, licensed staff should have created and updated a care plan. The DON stated the importance of the care plan was to direct the resident's care and provide the residents with the best possible interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P/P) titled, Care Planning- IDT, revised 4/2017, the P/P indicated facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. During a review of the facility's P/P titled, Change in resident's condition or status, revised date 12/2017, the P/P indicated: 1. Identify underlying problem causing the condition change. 2. Establish a measure goal for resolution of the condition. 3. Develop a plan to treat the condition; observe and monitor resident's response to treatment. 4. Preventive measure, safety measure and resident education. Observation and reporting of complications. b. During a review of Resident 99's Admission Record (Face Sheet), the Admission Record indicated Resident 99 was admitted to the facility on [DATE]. Resident 99's diagnoses included dementia without behavioral disturbance (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes and impaired reasoning), hypothyroidism (occurs when your thyroid gland does not produce enough of certain crucial hormones), and acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity (occurs when a blood clot forms in a vein located deep inside the body). During a review of Resident 99's Minimum Data Set (MDS), assessment and care-screening tool, dated 5/12/2021, the MDS indicated Resident 99 had severe cognitive (thought process) impairment. The MDS indicated Resident 99 required extensive to total assistance with activities of daily living ([ADLs] self-care activities performed daily, such as eating, dressing, bathing, and toilet use). During an observation on 5/25/2021 at 11:18 a.m., Resident 99 was observed in bed with two full siderails in the up position. During an interview and concurrent record review of Resident 99's physician's order, on 5/26/2021 at 8:25 a.m. with Registered Nurse 1 (RN 1) and Minimum Data Set (MDS) Coordinators 1 and 2, MDS Coordinators 1 and 2 verified the physician's order indicated for the use of a low bed with two-quarter siderails, and one-fourth siderails to prevent the resident from rolling out of bed. RN 1 stated a side-rail assessment should be done upon admission and during the quarterly assessment and annually thereafter. RN 1 and MDS Coordinators 1 and 2 verified there was no care plan to address the use of two full siderails. During a review of the facility's policy and procedure (P/P) titled, Proper use of Siderails, revised 4/2017, the P/P indicated side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P/P titled, Use of restraint, revised 4/2017, the P/P indicated prior to placing a resident in restraints, there shall be a pre- restraining assessment and review to determine the need for restraints. The P/P indicated assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. 44088

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview, and record review, the facility failed to revise/update a resident care plan for oxygen use for one sampled resident (Resident 92). This deficient practice had the potential for Resident 92 not to receive specific interventions to address respiratory needs. Findings: During a review of Resident 92's Admission Record, the Admission Record indicated Resident 92 was readmitted to the facility on [DATE]. Resident's 92 diagnoses included Parkinson's disease (brain disorder that leads to shaking, stiffness, and difficulty with walking, balance, and coordination), acute pulmonary edema (fluid buildup in the lungs), chronic diastolic heart failure (occurs when your heart muscle does not pump blood as well as it should, and anemia (lack of healthy red blood cells to carry adequate oxygen to your body's tissues). During a review of Resident 92's Minimum Data Set (MDS), resident assessment and care-screening tool, dated 5/5/2021, indicated Resident 92 was rarely/never understood and rarely /never understands. The MDS indicated Resident 92 had short term and long-term memory problems. The MDS indicated Resident 92 required extensive to total assistance with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing. During a review of Resident 92's physician's order, dated 11/22/2020, the physician's order indicated may administer oxygen (O2) 2 liters per minute (L/min) via nasal canula (n/c). May titrate to keep O2 saturation greater than (>) 92 percent (%) (Normal Reference Range [NRR] 92 to 100%) every shift. During a concurrent observation, interview, record review on 5/26/2021 at 6:55 a.m. with Licensed Vocational Nurse 6 (LVN 6) and the Director of Nursing (DON), LVN 6 stated Resident 92 was to receive O2 at 2-3 L/min. LVN 6 verified Resident 92's physician's order indicated to administer O2 at 2 L/min. Resident 92's O2 was observed at 2.5 L/min. The DON verified the flow meter on the oxygen tank did not match the physician's order. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. John of God Retirement	2468 South St Andrews Place Los Angeles, CA 90018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review of Resident 92's medical record on 5/26/2021 at 6:59 a.m. with LVN 6 and the DON, LVN 6 stated the nurses checked Resident 92's oxygen saturation at the start of the shift and at end of the shift. LVN 6 stated they tried weaning Resident 92 off of the O2, but the resident desaturates (a decrease in oxygen saturation level). LVN 6 verified Resident 92 was receiving O2 at 2.5 L/min. LVN 6 stated he could not locate Resident 92's care plan regarding O2 use. LVN 6 stated care plans were initiated and implemented when there was a change of condition and new order. LVN 6 stated a new admission care plan was usually completed by the admission nurse. The DON stated the care plan on O2 use would be done by the MDS nurse and the Interdisciplinary team ([IDT] group of different disciplines working together towards a common goal for a resident) updated it during the IDT meetings. The DON stated they should have an active care plan, and the one located in the electronic medical record system was overdue on 5/12/2021 for revision/updates and discontinued. During a review of the facility's policy and procedure (P/P) titled, Care Planning-IDT, revised 4/2017, the P/P indicated a comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment(MDS).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30840 Based on observation, interview, and record review, the facility failed to ensure: 1. Nursing staff met professional standards of quality and competency, for proper medication administration technique of one (1) out of two (2) licensed nurses observed administering medications, as evidenced by the facility's failure to ensure that three (3) medications were administered to three (3) residents, out of six (6) total residents observed during medication administration (med pass). This deficient practice had the potential for harm to the residents due to not receiving medications indicated for nutritional deficiencies caused by their individual medical conditions. 2. Nursing staff met professional standards of quality and competency, for proper medication administration technique as evidenced by the facility's failure to ensure that one narcotic sleep medication was administered to a resident with a physician order. This deficient practice had the potential for harm to the resident due to the administration of a discontinued narcotic sleep medication based on the absence of documented sleeplessness and no physician order. 3. Nursing staff failed to meet the professional standards of quality and competency, for proper medication administration and supervision in a timely manner. This deficient practice had the potential for harm to the resident and possibly other residents. These medications were left unsupervised and were not administered in a timely manner. 4. Nursing staff failed to meet the professional standards of quality and competency, by ensure to obtain a complete order for the use of a padded helmet for head protection. This deficient practice had the potential for the resident to cause physical self-inflected harm from the resident hitting his head using the palm of his hands. Cross referenced F755. Findings 1a. During an observation, at Station St, [NAME], on 5/26/2021, from 8:40 a.m. to 9:05 a.m., of Resident 46's morning medication administration (med pass), at Station St. [NAME] Medication Cart, Licensed Vocational Nurse 2 (LVN 2) did not administer the morning dose of Vitamin B 12 (cyanocobalamin, a nutrient that helps keep the body's nerve and blood cells healthy and helps make DNA, the genetic material in all cells. Vitamin B12 also helps prevent anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood, which makes people tired and weak) SL (sublingual, administered under the tongue) 2500 micrograms ([mcg] unit of measurement) Tablet, one tablet by mouth. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 46's physician orders, dated 9/29/2020, at 9:37 a.m., the physician's orders indicated, Vitamin B-12 Tablet Sublingual 2500 mcg (cyanocobalamin), give 1 tablet by mouth one time a day for supplement During a review of Resident 46's Admission Record (Face Sheet), the Admission Record indicated Resident 46 had diagnoses that included Vitamin B12 deficiency anemia. During an interview on 5/25/2021 at 8:57 a.m. with LVN 2, LVN 2 stated, Did not give today's dose, ran out of floor stock, re-ordered from pharmacy two days ago, 5/23/2021, but did not receive it. Yesterday, there was 1 or 2 tablets left, and resident received yesterday's dose. During an interview on 5/25/2021 at 12:59 p.m. with LVN 2, LVN 2 stated, Sublingual tablet coming this afternoon, will arrive on next run (delivery). 1b. During an observation, at Station St, [NAME], on 5/26/2021, from 9:05 a.m. to 10:11 a.m., of Resident 7's morning medication administration (med pass), at Station St. [NAME] Medication Cart, LVN 2 did not administer the morning dose of Multivitamin Tablet (used to provide vitamins that are not taken in through the diet. Multivitamins are also used to treat vitamin deficiencies caused by illness, pregnancy, poor nutrition, digestive disorders, and many other conditions). During a review of Resident 7's physician orders, dated 9/4/2018, at 7:58 p.m., the physician's order indicated, Multi Vitamin Tablet (Multiple Vitamin), give 1 tablet by mouth one time a day for supplement. During a review of Resident 7's Admission Record (Face Sheet), dated 1/9/20, the Admission Record indicated Resident 7's diagnoses included anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood, which makes people tired and weak) and dysphagia (difficulty swallowing). 1c. During an observation, at Station St, [NAME], on 5/26/2021, from 10:20 a.m. to 10:49 a.m., of Resident 23's morning medication administration (med pass), at Station St. [NAME] Medication Cart, LVN 2 did not administer the morning dose of Multivitamin Tablet. During a review of Resident 23's physician orders, dated 9/22/2020, at 7:08 p.m., the physician orders indicated, Multivitamin Tablet (Multiple Vitamin), give 1 tablet by mouth one time a day for supplement. During a review of Resident 23's Admission Record (Face Sheet), dated 9/10/2019, the Admission Record indicated Resident 23's diagnoses included diverticulosis (a condition in which small, bulging pouches develop in the digestive tract) of intestine, part unspecified, without perforation or abscess without bleeding. During an interview on 5/25/2021 at 9:25 a.m., while holding a bottle of multivitamin with minerals, with LVN 2, LVN 2 stated, I put in a request, and Central Supply stated that this is the only one they have. I have never given this product (multivitamin with minerals) before. The order says Multivitamin tablets. I will check with Central Supply to see if they have Multivitamin tablets. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/26/2021 at 9:35 a.m. with LVN 2, LVN 2 stated, Central Supply stated that it is out of stock, on back order. This (multivitamin with minerals) is the only one they have. They don't know when it (multivitamins) is going to arrive. I will order it (multivitamins) from pharmacy. I will notify the doctor and let him know that it (multivitamins) is back-ordered, and I will ask him what he wants to do, to hold it until it arrives from pharmacy. I am not going to give that one (multivitamin with minerals). During an interview on 5/26/2021 at 12:59 p.m. with LVN 2, LVN 2 stated, Out of stock, physician stated hold (doses) until it (multivitamins) is stocked. During a review of the facility's policy and procedures (P/P) titled, Administering Medications, revised 4/2017, the P/P indicated, medications shall be administered in accordance with the orders, including any required time frame. 2. During an observation, on 5/26/2021 at 3:57 p.m., on inspection of the Station Bl. Eustachio Kugler Medication Cart locked narcotics compartment, Resident 98's medication card for Temazepam (Restoril, a sleeping pill used to treat insomnia) 15 milligrams ([mg] unit of measurement) Capsule indicated an end date of 2/28/2021. During an interview on 5/26/2021 at 3:57 p.m. with LVN 9 regarding Temazepam 15 mg Capsule, LVN 9 stated, It was discontinued on 2/28/2021, but the last time it was given was 3/5/2021. During a review of Resident 98's Admission Record (Face Sheet), the Admission Record indicated Resident 98's diagnoses included insomnia and anxiety disorder. During a review of Resident 98's Order Summary Report, dated 1/29/2021, the Order Summary Report indicated, Restoril Capsule 15 mg (Temazepam), give one capsule by mouth at bedtime for sleeplessness, informed consent obtained by MD for use of drug, order date 1/21/2020, start date 1/21/2020. During a review of Resident 98's Physician Telephone Orders slip, dated 1/29/2021,the Physician Telephone Orders slip indicated, Temazepam 15 mg Cap (capsule), one tablet by mouth at bedtime, #30 x 2 (quantity 30 times 2) During a review of Resident 98's Medication Administration Record (MAR) for February 2021, the MAR indicated two entries for Restoril. The first entry indicated, Restoril Capsule 15 mg (Temazepam), give 1 capsule by mouth at bedtime for sleeplessness, informed consent obtained by MD for use of drug, Order Date 1/21/2020, and D/C (discontinue) Date 2/3/2021, 6:35 a.m. The second entry indicated, Restoril Capsule 15 mg (Temazepam), give 15 mg by mouth at bedtime for insomnia for 30 days M/B (manifested by) sleeplessness, informed consent obtained by MD for use of drug., Order Date 1/29/2021, 4:21 p.m. The calculation of the 30 day stop date indicated 2/28/2021. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 98's Electronic Medication Administration Record (eMAR), the eMAR indicated three Restoril entries. The first entry, under Order Status of Discontinued, indicated, Restoril Capsule 15 mg (Temazepam), give 1 capsule by mouth at bedtime for sleeplessness ., Order Date 1/21/2020, End Date 2/3/2021. The second entry, under Order Status of Completed, Reason of Duplicate, indicated, Restoril Capsule 15 mg (Temazepam), give 1 capsule by mouth at bedtime for insomnia for 30 days manifested by sleeplessness ., Order Date 1/29/2021, End Date 2/28/2021. The third entry, under Order Status of Discontinued, indicated, Restoril Capsule 15 mg (Temazepam), give 1 capsule by mouth at bedtime for insomnia for 30 days manifested by sleeplessness ., Order Date 1/29/2021, End Date 1/29/2021. In summary, the three orders were discontinued on 2/3/2021, 2/28/2021, and 1/29/2021, respectively. During a review of Resident 98's Order Summary Report, dated 3/1/2021, the Order Summary Report indicated no order for Restoril Capsule (Temazepam) 15 mg. During a review of Resident 98's MAR for March 2021,the MAR indicated no order for Restoril 15 mg Capsule (Temazepam) 15 mg. The section on Monitor episodes of inability to sleep on 3-11 (3 p.m. to 11 p. m. shift) and 11-7 (11 p.m. to 7 a.m. shift) tally by hashmarks every evening and night shift, order date 1/20/2020 at 11:30 a.m., indicate zero 0 episodes on 3/1/2021, 3/2/2021, 3/3/2021, 3/4/2021, and 3/5/2021. During a review of Resident 98's Controlled or Antibiotic Drug Record for Restoril (Temazepam) 15 mg Capsule, the Controlled or Antibiotic Drug Record indicated three administration dates and times after the orders were discontinued, on date 3/1/2021, time 2100 (9 p.m.), on date 3/4/2021, time 2100, and on date 3/5/2021, time 2100. A fourth entry indicated Wasted. The recorded number of capsules indicated a starting quantity of 30 and remaining quantity of 26. The corresponding medication card, labeled, Temazepam 15 mg Capsule, Take 1 cap by mouth at bedtime (routinely), indicated four empty bubbles, starting from bubble 30 to bubble 27, with 26 capsules physically remaining. During a review of the facility's policy and procedures (P/P) titled, Administering Medications, revised date 4/2017, the P/P indicated, Policy Statement .Medications shall be administered in a safe and timely manner, and as prescribed .Policy Interpretation and Implementation .Medications must be administered in accordance with orders, including any required time frame . 3. During a review of Resident 9's Admission Record (Face Sheet), the Admission Record indicated Resident 9 was admitted to the facility on [DATE], and last readmitted on [DATE]. Resident 9's diagnoses included dysphagia (difficulty of swallowing), transient cerebral ischemic attack (a temporary period of symptoms similar to those of a stroke), urinary tract infection ([UTI] an infection in any part of the urinary system, the kidneys, bladder, or urethra), and abnormalities of gait (walk) and mobility, and muscle weakness. During a review of Resident 9's Minimum Data Set (MDS), a resident assessment and care-screening tool,) dated 2/12/2021, the MDS indicated Resident 9 had no cognitive (thought process) impairment. During an observation on 5/25/2021 at 11:24 a.m., Resident 9 was observed with multiple medications in a medicine cup on her bedside table. Resident 9 stated it would take her three hours to finish taking her medications and stated she had been taking medications on her own for more than a year. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/27/2021 at 1:43 p.m. with LVN 2, LVN 2 stated if a resident self-administered medications, the facility needed to obtain an order from the resident's primary physician and initiate a care plan for self-medication administration. LVN 2 stated if a resident had all of their medications and was taking it by themselves that was considered self-medication administration. During a concurrent interview and record review of Resident 9's medical record with LVN 2, LVN 2 verified there was no order and there was no care plan for self-medication administration. LVN 2 stated there was the potential for the resident to not take all the medication and would not get the desired effect of the medications. LVN 2 stated the licensed nurse should not leave the resident until all the medications were taken and it should be properly documented. During a review of the facility's policy and procedure (P/P) titled, Administering Medications, revised on 4/2017, the P/P indicated medications shall be administered in a safe and timely manner, and as prescribed. The P/P indicated only persons licensed or permitted by this State to prepare, administer, and document the administration of medications may do so. Medications must be administered in accordance with the orders, including any required time frame. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. 4. During an observation and concurrent interview on 5/25/2021 at 11:49 p.m., there were four medications in a medicine cup at Resident 37's bedside. Resident 37 stated LVN 5 placed the medications at the bedside during the earlier medication pass. Resident 37 stated the medication was not taken because the resident requested another medication that was not provided. During an interview on 5/25/2021 at 12:00 p.m. with LVN 5, LVN 5 stated Resident 37 did not take the medications at the bedside during the medication pass earlier because Resident 37 was waiting for LVN 5 to call the physician about another medication request. LVN 5 stated the medications that were observed in the medicine cup was Metformin (medication that lowers blood sugar levels and is typically given before meals), B-12 Tablet, Multivitamin, and Colace (medication used to prevent constipation (when stools back up in the colon). LVN 5 stated the Medication pass was at 9 a.m. on 5/25/2021 and that the medications should have been dispensed to Resident 37 no later than 10 a.m. LVN 5 stated if a resident refused to take medications, during med pass, the licensed nurse should try to encourage the resident to take the medication three times while leaving the medication at the bedside. LVN 5 stated the licensed nurse should watch the resident take the medications. During an observation on 5/25/2021 at 12:10 p.m., Resident 37 agreed to take the medications that were left at the bedside as LVN 5 watched. During a review of Resident 37 eMAR for May 2021, the eMAR indicated Metformin administration order was for 0800 on 5/25/2021, Multivitamin administration order was for 0900 on 5/25/2021 and the Colace order was for 0900 on 5/25/2021. During a review of Resident 37's Accucheck (monitoring system used to monitor blood sugar) Summary report dated 5/25/2021 at 6:31 a.m., the Accucheck Summary report indicated a reading of 141 milligrams/deciliter ([mg/dl] unit of measurement). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/25/2021 at 12:15 p.m. with LVN 5, LVN 5 stated the facility's medications administration policy indicated medications could be administered one hour before or one hour after the administration pass. LVN 5 stated if an Accucheck was not performed prior to administering Metformin, the result could cause the residents' blood sugar levels to lower and ultimately cause a shock. During a review of the facility's policy and procedures (P/P), titled, Administering Medications, revised date 4/2017, the P/P indicated, Policy Statement .Medications shall be administered in a safe and timely manner, and as prescribed .Policy Interpretation and Implementation .Medications must be administered in accordance with orders, including any required time frame . 5. During an observation on 5/24/2021 at 8:30 a.m., Resident 96 was observed in a wheelchair (W/C) with a helmet on for head protection, slapping himself on the side of his head as Licensed Vocational Nurse 30 (LVN 30) was pushing the resident down the hallway. LVN 30 intervened to stop the resident from hitting himself. During a review of Resident 96's Admission Record, Resident 96's diagnoses included dementia without behavioral and cerebral infarction (an area of necrotic tissue in the brain deprived of oxygen). During a review of Resident 96's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 2/12/2021, the MDS indicated Resident 96's had cognitive impairment. The MDS indicated Resident 96 required limited to extensive assistance with activity of daily livings ([ADLs] self-care activities performed on a daily basis, such as turning, feeding, and toilet use). The care area assessment (CAA) of the MDS indicated Resident 96 triggered for cognition loss/dementia requiring staff member to physically assist the resident. During a review of Resident 96' physician's order dated 7/4/2020, the physician's order indicated helmet for head protection without time intervals, or duration. During a review of Resident 96's care plan dated 2/26/2021, the care plan indicated Resident 96 was to wear a helmet to protect the resident from injury related to the resident's tendency to hit himself on the head with his hands. The goal indicated Resident 96 would be free from complications related to the use of a helmet as head protection. The staff's interventions included to apply the helmet as ordered. During a tour of the facility on 5/24/2021 at 9:30 a.m., there was an unusual noise coming from room [ROOM NUMBER]-A. Resident 96 was observed sitting up on the side of the bed with his feet on the floor using both hands hitting himself on the side of his head for approximately thirty seconds. Resident 96 was not wearing a helmet. The helmet was placed on top of the bedside stand. During an interview on 5/25/2021 at 9:40 a.m. with LVN 30, LVN 30 stated there was no order for duration, or specific timeframe when to apply Resident 96's. LVN 30 stated he would call Resident 96's physician to obtain a complete order. During a review of the facility's policy and procedure (P/P) titled, Safety and Supervision of Residents, dated 4/2017, the P/P indicated implementing interventions to reduce accident risks including the staff ensure that interventions are implemented. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	32022 41699 43436

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on observation, interview, and record review, the facility failed to ensure hand rolls were applied to both hands, per the resident's care plan to prevent worsening contractures (permanent shortening and hardening of muscles, tendons, or other tissue leading to deformity and rigidity of joints) for one of 21 sampled residents (Resident 44). This deficient practice had the potential for worsening contractures and skin breakdown to the palms of Resident 44's hands. Findings: During a review of Resident 44's Admission Record (Face Sheet), the Admission Record indicated Resident 44 was admitted to the facility on [DATE]. Resident 44's diagnoses included dysphagia (difficulty swallowing), abnormalities of gait (walk) and mobility, dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), encephalopathy (a disease in which the functioning of the brain is affected that alters brain function or structure) and urinary tract infection ([UTI] an infection in any part of your urinary system - your kidneys, ureters, bladder and urethra). During a review of Resident 44's Minimum Data Set (MDS), a resident assessment and care-planning tool, dated 3/19/2021, the MDS indicated Resident 44 had severe cognitive (thought process) impairment. During a review of Resident 44's care plan dated 4/7/2021, the care plan indicated to provide restorative nursing assistant (RNA) services five times a week. The care plan indicated to provide hand rolls for both hands to prevent further contractures to the hands. During an observation on 5/25/2021 at 11:41 a.m., Resident 44 was observed without hand rolls to both hands. During an interview on 5/26/2021 at 10:14 a.m. with RNA 1, RNA 1 stated RNA services were ordered from the rehabilitation department and they follow the orders accordingly. RNA 1 stated whatever was written in the order and reflected in the care plan should be followed. During an interview on 5/27/2021 at 10:19 a.m. with RNA 1, RNA 1 stated she may have missed applying Resident 44's hand rolls that morning and did not have any reason or explanation regarding the incident. RNA 1 stated the potential of not applying the hand rolls as ordered increased the resident's risk for skin breakdown on both palms and it put Resident 44 at high risk for further hand contractures. During a review of the facility's policy and procedure (P/P) titled, Rehabilitative Nursing Care, revised 8/2017, the P/P indicated Rehabilitative nursing care is provided for each resident admitted . The P/P indicated: (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. General rehabilitative nursing care is that which does not require the use of a Qualified Professional Therapist to render such care. 2. Nursing personnel are trained in rehabilitative nursing care. Our facility has an active program of rehabilitative nursing which is developed and coordinated through the resident's care plan. 3. The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. 4. Rehabilitative nursing care is performed daily for those residents who require such service. Such program includes, but is not limited to: a. Maintaining good body alignment and proper positioning. b. Encouraging and assisting bedfast residents to change positions at least every two (2) hours (day and night) to stimulate circulation and to prevent decubitus ulcers, contractures, and deformities. c. Making every effort to keep residents active and out of bed for orders, and encouraging residents to achieve independence in activities of daily living by teaching self-care and ambulation a activities. d. Assisting residents to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests, if necessary. e. Assisting residents with their routine range of motion exercises. 5. Through the resident care plan, the goals of rehabilitative nursing care are reinforced in the Activities Program, Therapy Services, etc.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43436 Based on observation, interview, and record review, the facility failed to provide appropriate and consistent activities for one of 21 sampled residents (Resident 82). This deficient practice had the potential to decrease physical, cognitive (thought process), sense of belonging, and emotional health. Findings: During a review of Resident 82's Admission Record (Face sheet), the Admission Record indicated the resident was admitted to the facility on [DATE]. Resident 82's diagnoses included transient ischemia attack (when blood flow to the brain is blocked for a short amount of time) and diabetes mellitus (high blood sugar). During a review of Resident 82's Minimum Data Set (MDS), a standardized assessment tool and care-screening tool, dated 4/26/2021, the MDS indicated the resident had no cognitive impairment. The MDS indicated Resident 82 was independent with activities of daily living ([ADL] self-care activities performed on a daily basis, such as eating, dressing, toilet use, and personal hygiene), transfer, bed mobility, and locomotion on unit and off unit. The MDS indicated Resident 82 preferred activities that included listening to music, keeping up with the news, participating with groups of people, participating in favorite activities, being outside to get fresh air, and participating in religious activities. During an observation on 5/25/2021, from 1:03 p.m. to 1:20 p.m., Resident 82 was observed in the room sitting on the side of the bed in silence. There was no music playing and the television (TV) was off. During a review of Resident 82's Activity assessment dated ,d+[DATE], the Activity Assessment indicated it was very important to the resident keep updated on the news, and the resident would participate in mass every day of the week. During an interview on 5/25/2021 at 1:13 p.m. with Resident 82, Resident 82 stated she had laptop but has not had Internet access for over six weeks. Resident 82 stated that she felt disconnected and lonely without Internet access. Resident 82 stated, This is a big loss for me, this is how I stay in touch. Resident 82 stated the Internet was how the resident was updated with news, family and friends. Resident 82 stated she spoke to Information Technology Staff 1 (IT 1) and was told to purchase a hotspot (a wireless network that offers Internet access). Resident 82 stated she purchased a hotspot, and it changed the edition of the word application that she typically used and her family member was assisting in returning the hotspot. Resident 82 stated IT 1 informed the resident there was Internet availability for thirty minutes per day, but no one has assisted her with access. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/1/2021 at 1:45 p.m. with IT Supervisor, the IT Supervisor stated the Internet was only provided to staff and not residents. The IT Supervisor stated there was Internet available through the Spectrum WIFI (a wireless connection that will allow computers, laptops and phones Internet access) in the common areas of the facility. The IT Supervisor stated he did not know who was responsible for notifying the residents of the WIFI availability. The IT Supervisor stated it was possibly Social Services responsibility. During an interview on 6/3/2021 at 3:03 p.m. with Social Services (SS), SS stated there was WIFI or Internet access the residents could use for thirty minutes per day. The SS stated the activities staff would be responsible or the social services department could assist residents as needed with Internet access. The SS stated she had not assisted any residents with accessing WIFI or free Internet within the facility. During an interview on 5/27/2021 at 1:22 p.m. with the Activity Director (AD), the AD stated that an activities assessment was completed for Resident 82. The AD stated Resident 82 had a laptop and a phone, and had seen the resident on the phone but not on the laptop. During an interview on 6/1/21 at 3:21 p.m. with the Administrator (ADMIN), the ADMIN stated there was free limited access for thirty minutes per day but it was not advertised to residents within the facility. During a review of the facility's undated policy and procedure (P/P) titled, Activities/Social Services, the P/P stated a resident shall have the right to choose the types of activities and social events in which they wish to participate as long as such activities do not interfere with the rights of other residents in the facility.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on observation, interview and record review, the facility failed to ensure that one of one residents (Resident 33), who was drinking alcohol, was provided with the needed care and services by failing to: 1. Ensure Resident 33 who was diagnosed with dementia (progressive impairments to memory, thinking and behavior, that affect the ability to perform everyday activities) was monitored for the consumption of alcohol and the accessibility of the alcohol located at the resident's bedside. 2. Ensure Licensed nurses documented on the Medication Administration Record (MAR) regarding the implementation of the physician's orders for alcohol ordered and consumed by Resident 33. 3. Consult with the pharmacist regarding Resident 33's alcohol consumption for possible interactions with medications. These deficient practices had the potential for Resident 33 to have an increase in alcohol consumption (excessive) and interactions with medications that could lead to dizziness, drowsiness, impaired thinking, judgement, and motor coordination, that placed the resident at risk for injury. On 5/28/2021 at 4:00 p.m., during a recertification survey, the Department of Public Health called an Immediate Jeopardy (IJ) situation (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident), in regards to Resident 33 having a large amount of alcohol in the room on the floor and in her unlocked personal refrigerator. The licensed nurses had no documentation of the amount of beer consumption by Resident 33 in the MAR. The resident has severe cognitive impairment, and the consulting pharmacist did not check drug interaction with alcohol. The IJ was called in the presence of the Administrator (Admin) and the Director of Nursing (DON). On 5/29/2021 at 2:45 p.m., the Department of Public Health removed the IJ while onsite after the surveyors verified the facility implemented the Plan of Action ([POA] a detailed plan to address findings) via observations, interviews and record review, given by the DON which included: 1. All alcoholic beverages were removed from the resident's room immediately on 5/28/2021. 2. The alcoholic beverages were placed under secure lock in the medication room on 5/28/2021, whereas only the Licensed Nurses have access. 3. The resident shall consume alcoholic beverages per order under staff supervision with monitoring related to potential drug cross sensitivity with consumption of alcoholic beverages, including but not limited to the following symptoms: low blood pressure, dizziness, drowsiness, light headedness, fainting, changes in pulse or heart rate, confusion, difficulty concentrating, impaired thinking, impaired judgement, or impaired motor coordination every shift. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/27/2021 at 2:06 p.m. with Licensed Vocational Nurse 10 (LVN 10), LVN 10 stated wine was kept in Resident 33's personal refrigerator that was unlocked. LVN 10 stated the licensed nurses were responsible for pouring the alcohol in a medication cup, and sign it off at the time of administration in the MAR. LVN 10 stated beer was kept at Resident 33's bedside and in the refrigerator. There was no monitoring of how much intake the resident consumed. During a concurrent record review of Resident 33's care plan and concurrent interview with LVN 10 on 5/27/2021 at 2:06 p.m., LVN 10 stated there was no care plan for beer and wine to be kept at Resident 33's bedside. During an interview on 5/27/21 at 11:04 a.m. with Housekeeping (HK) 1, HK 1 stated, housekeeping was the one who cleaned the personal refrigerator of Resident 33 and it was always unlocked. During a concurrent observation and interview on 5/28/21 at 9:23 a.m. with Resident 33, in Resident 33's room there were three boxes of beer at the bedside and an unopened bottle of wine. In Resident 33's personal refrigerator was three cans of beers, and a bottle of wine observed. Resident 33 stated that she drank whenever she felt like drinking and as much as she wanted. During an interview on 5/28/2021 at 2:06 p.m. with Registered Nurse 1 (RN 1), RN 1 stated the nurses received a physician's order for beer or wine, was to check for allergies, check medications for black box warning (warning designed to call attention to serious or life-threatening risks), and if the family was aware. When asked regarding the policy for consumption of alcohol, RN 1 stated he was not fully aware of it. RN 1 stated the facility did not have a monitoring process on the MAR for the beer consumed by Resident 33. RN 1 was asked if there was documentation that the facility's pharmacist consultant was contacted for possible drug interaction with the alcohol and he was unable to provide an answer or documentation. During a telephone interview on 5/28/2021 at 12:29 p.m. with Pharmacy Consultant 1, Pharmacy Consultant 1 stated she came to review the medication regimen for the month of May because she was helping Pharmacy Consultant 2. Pharmacy Consultant 1 stated she rarely saw an order for alcohol consumption, but she needed to check for drug interactions. Pharmacy Consultant 1 stated she did not receive a call from the nurse supervisor regarding the alcohol consumption of Resident 33. Pharmacy Consultant 1 stated usually the facility waited until pharmacy consultant next monthly visit even if the order was in the middle of the month. During a review of Physician's order, dated 4/30/2021, indicated Resident 33 scheduled medications included: 1. Gabapentin (used to treat nerve pain) 100 milligrams ([mg] unit of measure) at bedtime for polyneuropathy, original order date 10/26/2020. 2. Lasix (medication used to remove excess fluid from the body) 40 mg, one time per day for hypertension (high blood pressure), original order date 6/15/2020. 3. Metoprolol Succinate (used to treat high blood pressure) Extended Release 25 mg tablet for hypertension. original order date 10/26/2020. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 5/28/2021 at 11:29 a.m. with the Dispensing Pharmacist, the Dispensing Pharmacist stated she went over Resident 33's medication list and stated all medication interact with alcohol especially when drinking excessively. The Dispensing Pharmacist stated Gabapentin should not be combined with alcohol, and any hypertension medication would interact with alcohol, extended release medication needed to avoid alcohol containing drinks. The Dispensing Pharmacist stated the facility's staff needed to initiate the call to the pharmacist to inform the pharmacist of the resident's physician's order to verify an interaction. During a review of facility's policy and procedure (P/P) titled, Alcoholic Beverages, revised 4/2017, the P/P indicated should such an order be received, the nurse supervisor receiving the order must contact the pharmacist to determine if any of the resident's current medications would interact with alcohol.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 44055 Based on interview and record review the facility failed to: 1. Have a system of communication between the Nursing and the Rehabilitation Departments to ensure Resident 52 received Restorative Nurse Assistant ([RNA] rehabilitative care for residents to maintain or regain physical, mental and emotional well-being) services after being discharged from hospice (care for person's in the final phase of life with a focus on comfort) services. 2. Ensure that Resident 52's refusal for RNA services was properly documented. 3. Ensure accurate assessments Resident 52 was not receiving hospice services. 4. Ensure Resident 52 was assessed on two scheduled quarterly assessments in 2020. These deficient practices had the potential for a decline in Resident 52's functional status. Findings: During a record review of Resident 52's Admission Record, dated 4/21/2021, the Admission Record indicated the resident's diagnoses included hemiplegia (inability to move one side of the body) and hemiparesis (weakness to one side of the body) following cerebral infarction affecting the right dominant side and acquired absence of the left and right leg below the knee. During a record review of Resident 52's Joint Mobility Assessment form, completed by Occupational Therapist 1 (OT 1 [OT] professional who specializes in improving one's ability to perform activities of daily living), dated 2/22/2019, the Joint Mobility Assessment form indicated Resident 52 exhibited a limitation of the right upper extremity (arm), bilateral (both) hips and both knees. The form indicated Resident 52 was assessed for joint mobility on 7/14/2020 and 10/17/2020. and was not assessed for joint mobility on two quarterly assessments. Resident 52's Joint mobility assessment document indicated that in 2020, Resident 52 was on hospice. During a record review of Resident 52's medical record, the medical record indicated Resident 52 was admitted under hospice on 9/25/2018, on 12/18/2019 hospice services were discontinued. The medical record indicated there was no orders for RNA services since Resident 52's admission. During an interview on 5/27/21 at 9:38 a.m. with Certified Nurse Assistant and RNA 1(CNA/RNA 1), CNA/RNA 1 stated Resident 52 had no orders for range of motion ([ROM] exercise aimed to improve movement of a specific joint). During an interview on 5/27/21 at 9:51 a.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 52 had no orders for ROM or physical therapy (PT) treatment orders. LVN 2 stated Resident 52 was paralyzed on the right upper arm and had bilateral below the knee amputations and might benefit from left-sided ROM. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/27/2021 at 12:32 a.m. with LVN 2, LVN 2 stated Resident 52 was not on hospice. During an interview on 5/27/21 at 12:50 p.m. with OT 1, OT 1 stated all patients were screened for joint mobility upon admission, quarterly and on an as-needed basis. OT 1 stated when a resident refused treatment, it was documented in the resident's chart. OT 1 stated residents with limited ROM would benefit from RNA services. During an interview on 5/27/21 at 12:51 p.m. with OT 1, OT 1 stated there was no system to inform him if a resident's hospice services were initiated or terminated. OT 1 stated communication of the initiation or termination of hospice services would be beneficial to prevent errors. OT 1 stated he was not aware Resident 52 had been off of hospice since 2019. OT 1 admitted he mistakenly charted Resident 52 was on hospice for all of 2020 and up until 4/15/2021. During an interview on 5/27/21 at 12:58 p.m. with OT 1, OT 1 stated Resident 52 refused ROM treatment and OT 1 failed to document the refusal. OT 1 stated Resident 52 did not want to be bothered with ROM treatment. OT 1 apologized for his mistake of not documenting properly, and charting the resident was on hospice even though Resident 52 was not under hospice care, and for not documenting the resident's refusal of recommended treatment. During an interview on 5/28/21 at 9:30 a.m. with OT 1 stated to maintain ROM, Resident 52 should receive RNA services but since the resident refused, RNA services were not ordered. OT 1 stated he did not notify Resident 52's physician of the refusal because that was not their protocol or process. During a record review of the policies and procedures (P/P) requested from the Rehabilitation Department, the P/P's indicated none of the policies specified the frequency of joint mobility assessments to be documented on their Joint mobility assessment forms.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43436 Based on observation, interview, and record review, the facility failed to ensure a physician's order to provide Glucerna (a meal replacement shake with low sugar content) was followed for one of 21 sampled residents (Resident 82). This deficient practice had the potential for Resident 82's therapeutic diet to not be followed. Findings: During a review of Resident 82's Admission Record (Face sheet), the Admission Record indicated the resident was admitted to the facility on [DATE]. Resident 82's diagnoses included transient ischemia attack (when blood flow to the brain is blocked for a short amount of time) and diabetes mellitus (high blood sugar). During a review of Resident 82's Minimum Data Set (MDS), a standardized assessment tool and care-screening tool, dated 4/26/21, the MDS indicated the resident had no cognitive (ability to make decisions, understand and learn) impairment. During an interview on 5/25/2021 at 1:03 p.m. with Resident 82, Resident 82 stated Glucerna was ordered by the doctor for her diabetes. Resident 82 stated the facility ran out of Glucerna over the last weekend. Resident 82 stated she was receive Glucerna daily at 2:30 p.m. Resident 82 stated the facility asked if the resident's family could provide the Glucerna and Resident 82 stated her family member provided six Glucerna shakes. During an observation on 5/26/2021 at 11:15 p.m., there were four Glucerna shakes observed in Resident 82's drawer. During an interview on 5/27/2021 at 1:43 p.m. with the Dietary Services Supervisor (DSS), the DSS stated Glucerna was ordered and supplied by the Central Supply Department. During an interview on 5/27/2021 at 1:47 p.m. with Registered Nurse 1 (RN 1), RN 1 stated the charge nurse was responsible for supplying Glucerna to the resident, if there was an order. RN 1 stated the Glucerna was kept in the treatment room and Central Supply replenished the Glucerna supply on the unit. RN 1 stated there were no order forms for Glucerna. During an interview on 5/27/2021 at 1:56 p.m. with Licensed Vocational Nurse (LVN 5), LVN 5 Resident 82 received Glucerna at 2 p.m. daily. During an observation on 5/27/2021 at 2 p.m., there was a case of Chocolate Glucerna observed with 1-2 Glucerna drinks missing from the case of 24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/27/2021 at 2:04 p.m. with Central Supply (CS), CS stated they were responsible for ordering supplies for residents. CS stated the charge nurse supplied an order form and CS stated they also make rounds and check if the shelves of the supplies were filled or if any items needed to be replaced. CS stated the orders and supply dates were kept on file for each station. CS stated the facility always had Glucerna and there had not been an order in a while because Glucerna was always in stock. During a review of Resident 82's Accucheck (A monitoring system used to monitor blood sugar levels) Summary report indicated the following blood glucose levels on the following days: 1. 5/18/21 at 1645 (4:45 p.m.) - 241 milligrams/deciliter (mg/dl [unit of measurement]). 2. 5/19/21 at 1640 (4:40 p.m.) - 250 mg/dl. 3. 5/20/21 at 1628 (4:28 p.m.) - 236 mg/dl. 4. 5/21/21 at 1708 (5:08 p.m.) - 241 mg/dl. 5. 5/22/21 at 1711 (5:11 p.m.) - 314 mg/dl. 6. 5/23/21 at 1655 (4:55 p.m.) - 252 mg/dl. 7. 5/24/21 at 1628 (4:28 p.m.) - 211 mg/dl. 8. 5/25/21 at 1732 (5:32 p.m.) - 173 mg/dl. 9. 5/26/21 at 1703 (5:03 p.m.) - 214 mg/dl. 10. 5/27/21 at 1720 (5:20 p.m.) - 215 mg/dl. During a review of Resident 82's physician's order dated 5/25/2021, the physician's order indicated to supply Resident 82 with Glucerna Supplement (Chocolate preferred) in the afternoon. During a review of the facility's inventory delivery form for April 2021, the inventory delivery form indicated the last delivery for Glucerna for Resident 82's nurses' station was on 4/20/2021. During a review of the facility's packing slip (a slip indicating when purchases and deliveries were made from vendors), the packing slip indicated an order of one case (quantity of 24) chocolate Glucerna was placed on 5/25/2021. During a review of the facility's policy and procedure (P/P), revised 1/1/2013, titled Inventory Control the P/P stated a facility representative should regularly check the inventory records to reconcile inventory. During a review of the facility's P/P titled, Self Administration, the P/P indicated that a resident assessment of self-administration and bedside storage are recorded and kept in the medical record if a resident demonstrates the ability to safely self-administer further assessment of safety of bedside storage is conducted.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43436 Based on interview and record review, the facility failed to ensure the physician's documentation of visits were in the medical records for two of 21 sampled residents (Residents 17 and 52): This deficient practice had the potential for delay of necessary services, poor continuity of care and follow-up on the resident's status. Findings: a. During a review of Resident 17's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE]. Resident 17's diagnoses included chronic kidney disease (gradual loss of kidney function over time) and dysphagia (difficulty swallowing). During a review of Resident 17's Quarterly Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 2/26/2021, the MDS indicated Resident 17 had no cognitive (process of understanding through thoughts or concepts) impairment. During an interview and concurrent record review on 6/1/2021 at 11:52 a.m. with Licensed Vocational Nurse 5 (LVN 5), LVN 5 verified there was no Physician Visit Notes in Resident 17's chart. LVN 5 stated the Medical Director (physician that provides healthcare facilities with leadership [MD 2]) visited the residents monthly and could be reached at any time of the day for orders or emergencies. During an observation on 6/1/2021 at 1:29 p.m., LVN 5 attempted to make a telephone call to MD 2 and was forwarded to an answering service that informed LVN 5 that MD 2 was not available at this time and could not be reached, there was not an alternate physician to speak to. During an interview on 6/1/2021 at 2:56 p.m. with Resident 17, Resident 17 stated he had not seen MD 2 in a very long time and forgot what MD 2 looked like. During a record review on 6/1/2021 at 3:01 p.m., MD 2's Physician Care Notes could not be located for 2021. During a review of the facility's policy and procedure (P/P) titled, Conformity with Laws and Professional Standards, dated 12/2017 indicated the facility is in conformity with all federal, state and local laws relating to resident rights and other relevant safety and health requirements. b. During an interview and concurrent record review of Resident 52's medical chart on 6/1/2021 at 11:20 a.m. with LVN 2, LVN 2 stated documentation of physician visits were in the progress notes in the physical chart not in the computer. LVN 2 verified physician visits from MD 1 were documented on 2/25/2020, 6/27/2020, 7/15/2020, 10/30/2020, 3/30/2021, and 4/29/2021. LVN 2 stated she was not sure why there was no documentation every month because MD 1 always made rounds. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review of Resident 52's medical chart on 6/1/2021 at 11:57 a.m. with Registered Nurse Supervisor 1 (RN 1), RN 1 stated physician visits were documented in the physical chart and according to the progress notes. RN 1 verified there were documented physician visits for Resident 52 was completed for 2/25/2020, 6/27/2020, 7/15/2020, 10/30/ 2020, 3/30/2021, and 4/29/2021. RN 1 stated MD 1 always made rounds and was not sure why there was no monthly documentation. During an interview on 6/1/21 at 12:10 p.m. with MD 1, MD 1 stated he saw Resident 52 every month except when the resident was hospitalized . MD 1 stated the progress notes should be in the chart and unsure what happened to the missing monthly notes. During an interview on 6/1/21 1:50 p.m. with Resident 52, Resident 52 stated he did not know who his physician was and if he visited every month.

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F 0755 Level of Harm - Minimal harm or potential for actual harm 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** 32022 Based on observations, interviews, and record reviews, the facility failed to ensure that: 1. Three (3) medications were administered to three (3) residents, out of six (6) total residents observed during medication administration (med pass). This deficient practice had the potential for harm to the residents due to not receiving medications indicated for nutritional deficiencies caused by their individual medical conditions. 2. One narcotic sleep medication was administered to a resident with a physician order. This deficient practice had the potential for harm to the resident due to the administration of a discontinued narcotic sleep medication based on the absence of documented sleeplessness and no physician order. 3. Ensure that one (1) medication was accurately entered into the facility's electronic Medication Administration Record (eMAR), physician's order sheet and order summary report in the resident's record. This deficient practice had the potential for harm to the resident due to a potential medication administration error. 4. Ensure Residents 9 and 37, who was observed with medications at the bedside, had an order, assessment, and care plan for the self-administration of medications. This deficient practice had the potential for Resident 9 and 37's medications to not be taken at the ordered administration time. Findings 1a. During an observation, at Station St, [NAME], on 5/26/2021, from 8:40 a.m. to 9:05 a.m., of Resident 46's morning medication administration (med pass), at Station St. [NAME] Medication Cart, Licensed Vocational Nurse 2 (LVN 2) did not administer the morning dose of Vitamin B 12 (cyanocobalamin, a nutrient that helps keep the body's nerve and blood cells healthy and helps make DNA, the genetic material in all cells. Vitamin B12 also helps prevent anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood, which makes people tired and weak) SL (sublingual, administered under the tongue) 2500 mcg (strength in microgram units) Tablet, one tablet by mouth. During a review of Resident 46's physician orders, dated 9/29/2020, at 9:37 a.m., the physician's orders indicated, Vitamin B-12 Tablet Sublingual 2500 mcg (cyanocobalamin), give 1 tablet by mouth one time a day for supplement. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 46's Face Sheet, the Face Sheet indicated Resident 46 had diagnoses that included Vitamin B12 deficiency anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood, which makes people tired and weak). During an interview on 5/25/2021 at 8:57 a.m. with LVN 2, LVN 2 stated, Did not give today's dose, ran out of floor stock, re-ordered from pharmacy two days ago, 5/23/21, but did not receive it. Yesterday, there was 1 or 2 tablets left, and resident received yesterday's dose. During an interview on 5/25/2021 at 12:59 p.m. with LVN 2, LVN 2 stated, Sublingual tablet coming this afternoon, will arrive on next run (delivery). 1b. During an observation, at Station St, [NAME], on 5/26/2021, from 9:05 a.m. to 10:11 a.m., of Resident 7's morning medication administration (med pass), at Station St. [NAME] Medication Cart, LVN 2 did not administer the morning dose of Multivitamin Tablet (used to provide vitamins that are not taken in through the diet. Multivitamins are also used to treat vitamin deficiencies caused by illness, pregnancy, poor nutrition, digestive disorders, and many other conditions). During a review of Resident 7's physician's orders, dated 9/4/2018, at 7:58 p.m., the physician's orders indicated Multi Vitamin Tablet (Multiple Vitamin), give 1 tablet by mouth one time a day for supplement. During a review of Resident 7's Face Sheet, dated 1/9/2020, the Face Sheet indicated Resident 7's diagnoses included anemia and dysphagia (difficulty swallowing). 1c. During an observation, at Station St, [NAME], on 5/26/21, from 10:20 a.m. to 10:49 a.m., of Resident 23's morning medication administration (med pass), at Station St. [NAME] Medication Cart, LVN 2 did not administer the morning dose of Multivitamin Tablet. During a review of Resident 23's physician's orders, dated 9/22/2020, at 7:08 p.m., the physician's order indicated, Multivitamin Tablet (Multiple Vitamin), give 1 tablet by mouth one time a day for supplement. During a review of Resident 23's Face Sheet, dated 9/10/2019, the Face Sheet indicated the resident's diagnoses included diverticulosis (a condition in which small, bulging pouches develop in the digestive tract) of the intestine, part unspecified, without perforation or abscess without bleeding. During an observation and interview on 5/25/2021 at 9:25 a.m. with LVN 2, LVN 2 was observed holding a bottle of multivitamin with minerals, LVN 2 stated, I put in a request, and Central Supply stated that this is the only one they have. I have never given this product (multivitamin with minerals) before. The order says Multivitamin tablets. I will check with Central Supply to see if they have Multivitamin tablets. During an interview on 5/26/2021 at 9:35 a.m. with LVN 2, LVN 2 stated, Central Supply stated that it is out of stock, on back order. This (multivitamin with minerals) is the only one they have. They don't know when it (multivitamins) is going to arrive. I will order it (multivitamins) from pharmacy. I will notify the doctor and let him know that it (multivitamins) is back-ordered, and I will ask him what he wants to do, to hold it until it arrives from pharmacy. I am not going to give that one (multivitamin with minerals). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/26/2021 at 12:59 p.m. with LVN 2, LVN 2 stated, Out of stock, physician stated hold (doses) until it (multivitamins) is stocked. During a review of the facility's policy and procedure (P/P) titled, Administering Medications, revised 4/2017, the P/P indicated medications shall be administered in accordance with the orders, including any required time frame. 2. During an observation on 5/26/2021 at 3:57 p.m., on inspection of the Station Bl. Eustachio Kugler Medication Cart locked narcotics compartment, Resident 98's medication card for Temazepam (Restoril, a sleeping pill used to treat insomnia) 15 mg (strength in milligrams) Capsule indicated an end date of 2/28/2021. During an interview on 5/26/2021 at 3:57 p.m. with LVN 9, regarding Temazepam 15 mg Capsule, LVN 9 stated, It was discontinued on 2/28/21, but the last time it was given was 3/5/21. During a review of Resident 98's Face Sheet, the Face Sheet indicated the resident's diagnoses included insomnia (inability to sleep) and anxiety disorder (feeling of unease, excessive worry). During a review of Resident 98's Order Summary Report dated 1/29/2021, the Order Summary Report indicated, Restoril Capsule 15 mg (Temazepam) , give one capsule by mouth at bedtime for sleeplessness, informed consent obtained by MD for use of drug, order date 1/21/2020, start date 1/21/2020. During a review of Resident 98's Physician Telephone Orders slip dated 1/29/21, the Physician Telephone Orders slip indicated Temazepam 15 mg Cap (capsule), one tablet by mouth at bedtime, #30 x 2 (quantity 30 times 2) During a review of Resident 98's Medication Administration Record (MAR) for February 2021, the MAR indicated two entries for Restoril. The first entry indicated, Restoril Capsule 15 mg (Temazepam), give 1 capsule by mouth at bedtime for sleeplessness, informed consent obtained by MD for use of drug, Order Date 1/21/2020, and D/C (discontinue) Date 2/3/2021, 6:35 a.m. The second entry indicated, Restoril Capsule 15 mg (Temazepam), give 15 mg by mouth at bedtime for insomnia for 30 days M/B (manifested by) sleeplessness, informed consent obtained by MD for use of drug., Order Date 1/29/21, 4:21 p.m. The calculation of the 30 day stop date indicated 2/28/2021. During a review of Resident 98's Electronic Medication Administration Record (eMAR) by PointClickCare, the eMAR indicated three Restoril entries. The first entry, under Order Status of Discontinued, indicated, Restoril Capsule 15 mg (Temazepam), give 1 capsule by mouth at bedtime for sleeplessness ., Order Date 1/21/2020, End Date 2/3/2021. The second entry, under Order Status of Completed, Reason of Duplicate, indicated, Restoril Capsule 15 mg (Temazepam), give 1 capsule by mouth at bedtime for insomnia for 30 days manifested by sleeplessness ., Order Date 1/29/2021, End Date 2/28/2021. The third entry, under Order Status of Discontinued, indicated, Restoril Capsule 15 mg (Temazepam), give 1 capsule by mouth at bedtime for insomnia for 30 days manifested by sleeplessness ., Order Date 1/29/2021, End Date 1/29/21. In summary, the three orders were discontinued on 2/3/2021, 2/28/2021, and 1/29/2021, respectively. During a review of Resident 98's Order Summary Report dated 3/1/2021, the Order Summary Report indicated no order for Restoril Capsule (Temazepam) 15 mg. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 98's MAR for the month of March 2021, the MAR indicated no order for Restoril 15 mg Capsule (Temazepam) 15 mg. The section on Monitor episodes of inability to sleep on 3-11 (3 p.m. to 11 p.m. shift) and 11-7 (11 p.m. to 7 a.m. shift) tally by hashmarks every evening and night shift, order date 1/20/2020 at 11:30 a.m., indicate zero 0 episodes on 3/1/2021, 3/2/2021, 3/3/2021, 3/4/2021, and 3/5/2021. During a review of Resident 98's Controlled or Antibiotic Drug Record for Restoril (Temazepam) 15 mg Capsule, the Controlled or Antibiotic Drug Record indicated three administration dates and times after the orders were discontinued, on date 3/1/2021, time 2100 (9 p.m.), on date 3/4/2021, time 2100, and on date 3/5/2021, time 2100. A fourth entry indicated Wasted. The recorded number of capsules indicated a starting quantity of 30 and remaining quantity of 26. The corresponding medication card, labeled, Temazepam 15 mg Capsule, Take 1 cap by mouth at bedtime (routinely), indicated four empty bubbles, starting from bubble 30 to bubble 27, with 26 capsules physically remaining. During a review of the facility's P/P titled, Administering Medications, revised date 4/2017, the P/P indicated, Policy Statement .Medications shall be administered in a safe and timely manner, and as prescribed .Policy Interpretation and Implementation .Medications must be administered in accordance with orders, including any required time frame . 3. During an observation, on 5/26/2021, at 10:20 a.m., at the St. [NAME], Medication Cart during the morning medication administration, LVN 2 was checking the eMAR for Resident 23's order Polyethylene Glycol 1450 (formulation code) against the physical container of Polyethylene Glycol (Miralax, an over-the-counter laxative used for constipation) 3350 (formulation code) Powder for Solution Osmotic Laxative, 17 gram (strength) per dose by mouth. LVN 2 did not dispense the Polyethylene Glycol 3350. During an interview on 5/26/2021 at 10:29 a.m. with LVN 2, LVN 2, while pointing to the eMAR showing Polyethylene Glycol 1450, stated, It is not the same. Let me go check with Central Supply. During an interview on 5/26/2021 at 10:37 a.m. with LVN 2, LVN 2 stated, Central Supply said it was 1450 was back-ordered. Regarding who inputs the medication order in the system, LVN 2 stated, The RNs (registered nurses). After the surveyor informed LVN 2 that the wrong product was inputted into the system, she stated, I am going to clarify with the doctor that Polyethylene Glycol 3350 is what he ordered. LVN did not administer the medication. During an interview on 5/26/2021 at 10:51 a.m. with LVN 8, regarding choices in e-MAR, PointClickCare, for Polyethylene Glycol, LVN 8 stated, 1450 was entered by [NAME] Letargo, RN Supervisor, on 11/23/2019 at 2:19 a.m. During a review of the steps in the e-MAR for entering Polyethylene Glycol powder indicated a menu of the formulations 1000, 1450, 1500, 3350, 4500, 8000, and 3350, 17 GM/SCOOP (generic formulation for Miralax). During an interview on 5/26/2021 at 11:02 a.m. with LVN 8, regarding the formulation 1450, LVN 8 showed that the e-MAR indicated, Medication Class: Pharmaceutical Adjuvants (an inactive ingredient in the pharmaceutical industry as a solvent, plasticizer, surfactant, ointment and suppository base, and tablet and capsule lubricant). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/26/2021 at 11:10 a.m. with LVN 8, regarding the formulation 3350, LVN 8 showed that the e-MAR indicated, Medication Class: Laxatives (medication that stimulates or facilitates evacuation of the bowels), Pharmaceutical Adjuvants During an interview on 5/26/2021 at 11:22 a.m. with the Director of Nursing (DON), the DON stated he did not have a policy and procedure for entering orders into the eMAR (electronic medication administration record). During an interview on 5/26/2021 at 12:59 p.m. with LVN 2, LVN 2 stated, Clarified with physician, order is Polyethylene Glycol 3350. LVN 2 stated she would administer the Polyethylene Glycol 3350 to Resident 23 today. During an interview on 5/26/2021 at 1:20 p.m. with Registered Nurse 1 (RN 1), regarding the inputting of Polyethylene Glycol 1450 instead of 3350, RN 1 stated, I was notified by the charge nurse that the order was for 1450, I called the doctor, and clarified the order for Polyethylene Glycol 3350. If you click the first Polyethylene Glycol without a label, it defaults to the 1450. I saw one or two orders this morning with 1450, and clarified the orders with the physicians, and they clarified it as 3350. The residents were [Resident 69] and [Resident 39]. During an interview on 5/26/2021 at 2:05 p.m. with the Central Supply Clerk (CSC), regarding which Polyethylene Glycol is in stock, the CSC stated, This one, pointing to three (3) bottles of Polyethylene Glycol 3350 Powder for Solution Osmotic Laxative, net weight 17.9 ounces (510 grams). The CSC stated that she does not have any other strength in stock. Regarding if there was a request by a nurse to order Polyethylene Glycol 1450, she stated, No. [LVN 2] came down here to looked for the 1450, and asked if we have 1450, and I said No, we only have one kind in stock, the stock we have is 3350. She (LVN 2) did not ask me to order 1450. If they asked me to order 1450, I would have ordered (it). She (LVN 2) was looking on her phone for what she needs, but I told her that we only have 3350. During an attempted interview on 5/26/2021 at 2:41 p.m. with the facility's Consultant Pharmacist (CP 2), CP 2 was unavailable to speak, as he was on vacation and would return to work on 6/1/2021. During a review of CP 2's Consultation Report, the Consultation Report indicated Resident 23's chart was reviewed on 2/19/2021, 3/15/2021, 4/13/2021, and 5/12/2021, with the printed statement, The following residents were reviewed and based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgment that at such time, the residents' medication regimens contained no new irregularities . During an interview on 6/1/2021 at 11:15 a.m., the surveyor informed CP 2 that Resident 23's order for Polyethylene Glycol 1450 was entered into the electronic medical records system (PointClickCare or PCC) on 11/23/2019, instead of Polyethylene Glycol 3350 (Miralax equivalent, a laxative). He stated that he was not aware that 1450 was one of the menu choices in the PCC electronic medical records system, nor that the 3350 is flagged with the 17 gram dose. He was aware that it was a pharmaceutical adjuvant, and not the Miralax (Polyethylene Glycol 3350) equivalent. The surveyor informed him that the correct directions were in the electronic medication administration record (eMAR), and that the correct product was administered to Resident 23. The surveyor informed CP 2 that two other residents also had the product Polyethylene Glycol 1450 entered into their medical records, and that the drug name was already corrected to 3350 by RN 1. CP 2 stated that he will speak to the DON to review all patients on Polyethyene Glycol and make sure they have 3350. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's pharmacy policy and procedures (P/P) titled, Physicians Medication Order, revised 4/2017, the P/P indicated under, Policy Interpretation and Implementation, indicated, Orders for medications must include: Name and strength of the drug .drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. Such orders are reviewed by the Pharmacist on a monthly basis. 4. During a review of Resident 9's Face Sheet (admission record), the Face Sheet indicated Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 9's diagnoses included dysphagia (difficulty of swallowing), transient cerebral ischemic attack (a temporary period of symptoms similar to those of a stroke), urinary tract infection ([UTI] an infection in any part of the urinary system, the kidneys, bladder, or urethra), abnormalities of gait and mobility, and muscle weakness. During a review of Resident 9's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 2/12/2021, the MDS indicated Resident 9 had no cognitive impairment (thought process). During an observation and concurrent interview on 5/25/2021 at 11:24 a.m. with Resident 9, Resident 9 was observed with multiple medications in a medicine cup on her bedside table. Resident 9 stated it would take her three hours to finish taking her medications and stated she has been self-administering her medications for more than a year. During an interview on 5/27/2021 at 1:43 p.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated if a resident wanted to do self-medication administration, the facility needed to get an order from the primary physician. LVN 2 stated there needed to be a care plan for self-medication administration. LVN 2 stated if a resident had all their medications in a cup and was taking it by herself, that was considered self-medication administration. During an interview and concurrent record review of Resident 9's chart on 5/27/2021 at 1:45 p.m. with LVN 2, LVN 2 verified there was no order and there was no care plan for self-medication administration. LVN 2 stated there was the potential the resident would not take the medications if the resident did not feel like taking the medicine and then the resident would not get the desired effect of the medications. LVN 2 stated the licensed nurse should not leave the resident until all the medications were taken and it should be properly documented. During a review of the facility's P/P titled, Administering Medications, revised on 4/2017, the P/P indicated medications shall be administered in a safe and timely manner, and as prescribed. 1. Only persons licensed or permitted by this State to prepare, administer, and document the administration of medications may do so. 2. Medications must be administered in accordance with the orders, including any required time frame. 3. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an observation and concurrent interview on 5/25/2021 at 11:49 p.m., there were four medications in a medicine cup at Resident 37's bedside. Resident 37 stated LVN 5 placed the medications at the bedside during the earlier medication pass. Resident 37 stated the medication was not taken at that time because Resident 37 requested another medication that was not provided. During an interview on 5/25/2021 at 12: 00 p.m. with LVN 5, LVN 5 stated Resident 37 did not take the medications at the bedside during the medication pass earlier that day because Resident 37 was waiting for LVN 5 to call the physician about another medication request. LVN 5 stated the medications were Metformin (medication that lowers blood sugar levels and is typically given before meals), B-12 Tablet, Multivitamin, and Colace (medication used to prevent constipation (when stools back up in the colon). LVN 5 stated the medication pass was at 9 a.m. on 5/25/2021 and the medications should have been dispensed to Resident 37 no later than 10:00 a.m. LVN 5 stated that during Medication Pass, if a resident refuses to take medications, to try to encourage three times while leaving the medication at the bedside. When LVN 5 was asked how it would be verified if the medication was taken by Resident 37, LVN 5 stated the nurse was to watch the resident take the medications. When LVN 5 was asked how it would be known if Resident 37 took medications or someone else took the medications, it was stated we are supposed to watch the resident take the medications. During an observation on 5/25/2021 at 12:10 p.m., LVN 5 asked Resident 37 if the resident was ready to take the medications at the bedside. Resident 37 agreed to take the medications and LVN 5 watched Resident 37 take the medications that were left at the bedside. During a review of Resident 37 eMAR dated May 2021, the eMAR indicated the Metformin administration order was for 8:00 a.m. on 5/25/2021, the Multivitamin administration order was for 9:00 a.m. on 5/25/2021, and the Colace order was for 9:00 on 5/25/2021. During a review of Resident 37 Accucheck (used to monitor blood sugar) Summary report dated 5/25/2021 at 6:31 a.m., the Accucheck Summary Report displayed a reading of 141 mg/dl (milligrams/deciliter). During an interview on 5/25/2021 at 12: 15 p.m. with LVN 5, LVN 5 stated medications could be administered one hour before or one hour after the scheduled administration pass. LVN 5 stated that if an Accucheck was not performed prior to administering Metformin, the result could cause the residents' blood sugar levels to lower and ultimately cause a shock. During a review of the facility's P/P titled, Administering Medications, revised 4/2017, indicated, the P/P indicated medications shall be administered in a safe and timely manner, and as prescribed. The P/P indicated medications must be administered in accordance with orders, including any required time frame. 41699 43436

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30840 Based on observation, interview and record review, the facility failed to ensure one of one sampled residents (Resident 33), who was drinking alcohol, was provided with a thorough drug regimen review. The facility's pharmacist consultant also failed to identify drug irregularities during the monthly Medication Regimen Review (MRR) when antipsychotic (Quetiapine Fumarate [medication used to treat psychosis]) medication was used for the treatment of psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality) without a documented clinical rationale for Resident 23 by failing to: 1. Ensure medications review for possible drug interactions (an interaction between a drug and another substance that prevents the drug from performing as expected) and/or irregularities when there was an order for the resident to consume alcohol while receiving prescribed medications. 2. Ensure licensed nurses contacted the pharmacist (a person who is professionally qualified to prepare and dispense medicinal drugs) to determine if any of the resident's current medications could interact with alcohol. This deficient practice had the potential for a drug/alcohol interaction, which could cause dizziness, drowsiness, impaired thinking, judgement, and motor coordination and placed Resident 33 at risk for injury, and had the potential for Resident 23 to receive uneccessary medication. On 5/28/2021 at 4 p.m., during a recertification survey, an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has cause, or is likely to cause, serious injury, harm impairment or death to a resident) was identified and declared under F756 for Resident 33. The facility's staff failed to consult with the facility's Pharmacy Consultant (PC) for possible irregularities or drug alcohol interactions when Resident 33 had a physician's order to consume alcohol (beer and wine). The IJ was called in the presence of Administrator (ADM) and the Director of Nursing (DON). During an interview on 5/29/2021 at 2:45 p.m., the DON submitted an acceptable Plan of Action ([POA] interventions to correct the deficient practices). The IJ was lifted at 2:45 p.m., after the team verified and confirmed the POA was implemented per observations, interviews, and record review, while onsite. The acceptable POA included the following for Resident 33: 1. All alcoholic beverages were removed from the resident's room immediately on 5/28/2021. 2. The alcoholic beverages were placed under secure lock in the medication room on 5/28/2021, whereas only the Licensed Nurses have access. 3. The resident shall consume alcoholic beverages per order under staff supervision with monitoring related to potential drug cross sensitivity with consumption of alcoholic beverages, including but not limited to the following symptoms: low blood pressure, dizziness, drowsiness, light headedness, fainting, changes in pulse or heart rate, confusion, difficulty concentrating, impaired thinking, impaired judgement, or impaired motor coordination every shift. (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. The Interdisciplinary Team (a group of health care professionals with various areas of expertise who work together toward the goals of the resident) met on 5/28/2021 to discuss the findings and formulated a plan of care with family/primary contact involvement, physician participation, and pharmacist review. The problem was resolved on 5/28/2021. 5. The facility conferred with the consulting pharmacist and received consultation with physician follow-up on 5/28/2021. The attending Physician visited the facility, reinterviewed the resident and documented his findings on 5/29/2021. 6. In-service to the monitoring process for alcohol consumption started on 5/28/2021 by the Director of Nursing, Registered Nurse (RN) Supervisors and/or designees at the point of problem identification. 7. The policy shall indicate that alcoholic beverages shall be treated as a medication and stored in the medication room on 5/28/2021. 8. The Director of Nursing will monitor the outcomes of the systemic changes and report on any trends during monthly Quality Assurance and Performance Improvement ([QAPI] proactive approach to quality improvement) meetings for three (3) months for further recommendations. Findings: a. During a review of Resident 33's admission record (Face sheet), the Face sheet indicated the resident was admitted to the facility on [DATE]. Resident 33's admitting diagnoses included toxic encephalopathy (a brain malfunction and toxic asserts the malfunction is caused by toxins on the brain), heart failure (a condition in which the heart cannot pump enough blood to meet the body's needs), atrial fibrillation (an irregular and often rapid heart rate) hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood), polyneuropathy (many nerves in different parts of the body are involved), dementia (progressive impairments to memory, thinking and behavior, that affect the ability to perform everyday activities). During a review of Resident 33's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 3/12/2021, the MDS indicated Resident 33 sometimes had the ability to understand and be understood. According to the MDS, Resident 33 required total assistance with activities of daily living ([ADLs] such as grooming, toileting, eating etc.). During a review of Resident 33 Physician's order Recapitulation (summary), dated 4/30/2021, the orders indicated Resident 33 was receiving the following medications: 1.Gabapentin 100 milligram ([mg]unit of measurement) at bedtime for polyneuropathy (simultaneous malfunction of many peripheral nerves (refers to parts of the nervous system outside the brain and spinal cord) throughout the body) with an original order date of 10/26/2020. 2. Lasix 40 mg, one time per day for hypertension (high blood pressure), original order date 6/15/2020. 3. Metoprolol Succinate Extended Release 25 mg tablet for hypertension with an original order date of 10/26/2020. (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 33's Recapitulation orders, the physician order indicated Resident 33 could have 30 cubic centimeter ([cc] unit of measurement) of wine three (3x) times a day with an original order date of 8/29/2019. The physician's order indicated Resident 33 could also have beer twice (2x) per week with an original order date of 3/17/2020. During a review of Resident 33's Medication Administration Record (MAR) for the wine administration for the months of May 1-31, 2021, indicated it was signed by several Licensed Vocational Nurses (LVNs), but there was no documentation for Resident 33's beer consumption. During an interview on 5/27/2021 at 2:06 p.m., Licensed Vocational Nurse (LVN 10) stated Resident 33's wine was kept in the resident's personal unlocked refrigerator at the bedside. LVN 10 stated the licensed nurses were the ones pouring the wine in the medication cup for the resident and then signing the MAR at the time the wine is given. LVN 10 stated Resident 33's beer was at the resident's bedside and some kept in the resident's personal refrigerator. LVN 10 stated there was no monitoring of how much beer Resident 33 consumed. During an interview on 5/27/2021 at 11:04 a.m., Housekeeping 1 stated she was the one who cleaned Resident 33's personal unlocked refrigerator. During a concurrent observation and interview on 5/28/2021 at 9:23 a.m., in Resident 33's room, there were three (3) boxes (36 cans) of beer containing alcohol at the resident's bedside and an unopened bottle of wine. In Resident 33's personal refrigerator a few cans of beer and a bottle of wine was observed. Resident 33 stated, she drinks whenever she wanted to drink and as much as she wanted. During an interview on 5/28/2021 at 2:06 p.m., with Registered Nurse (RN) 1, RN 1 stated the process for when the residents received an order to have beer or wine, was to check the resident's allergies and medication for black box warning (appears on a prescription drug's label and is designed to call attention to serious or life-threatening risks) and ensure the family was aware. RN 1 was asked about the facility's policy and procedure (P/P) for the resident consumption of alcohol. RN 1 stated he was not aware of a facility's P/P for alcohol consumption. RN 1 was asked if the staff were monitoring and documenting Resident 33's consumption of beer. RN 1 stated there was no documentation on the MAR or anywhere for the beer Resident 33 was consuming. RN 1 was asked if the pharmacy was contacted for possible drug and alcohol interaction, RN 1 was unable to answer and/or provide any documentation. During a review of Resident 33's Medication Regimen Review ([MRR] a review of all medications the resident was currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy) for the month of 5/2021, the MRR indicated there was no findings, changes or recommendations by the pharmacist. During a telephone interview on 5/28/2021 at 11:29 a.m., Pharmacist Consultant 1 (PC 1) stated she reviewed Resident 33's medication list and stated all the resident's medication interacts with alcohol, especially if the resident was drinking excessively. PC 1 stated Gabapentin and anti-hypertensive medications should not be combined with alcohol and any medication with an extended release (the drug is released slowly over time) alcohol should be avoided. PC 1 stated it was the facility's responsibility to initiate the call to the pharmacy of Resident 33's physician order to consume alcohol while receiving prescribed medications. (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 5/28/2021 at 12:29 p.m., Pharmacy Consultant 1 (PC 1) stated she came to the facility to review medication regimen for the month of 5/2021 because she was helping PC 2. PC 1 was asked what the process was if the physician orders alcohol consumption for resident while receiving medications. PC 1 stated she rarely sees an order for alcohol consumption but stated possible drug interaction should be check. PC 1 was asked if she had received a call from the facility's staff to check Resident 33 for a possible drug/alcohol interaction for the resident consuming alcohol while receiving prescribed medications. PC 1 stated she had not received a call from the staff regarding checking alcohol/drug interactions for Resident 33. During a review of the facility's P/P titled, Alcoholic Beverages with a revised date of 4/2017, the P/P indicated should such an order be received, the nurse supervisor receiving the physician's order must contact the pharmacist to determine if any of the resident's current medications would interact with alcohol. b. During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was admitted to the facility on [DATE]. Resident 23's diagnoses included dementia (progressive memory loss) and psychosis disorder. During a review of Resident 23's Minimum Data Set (MDS), a resident assessment and care-planning tool, dated 3/15/2021 indicated Resident 23 had the ability to make daily decision making. The MDS indicated Resident 23 required extensive assistance with activities of daily livings ([ADLs] self-care activities performed daily, such as eating, dressing, personal hygiene, and toilet use). The Care Area Assessment (CAA) of the MDS indicated Resident 23 triggered for psychotropic drug use requiring frequent assessment from staff. During a review of Resident 23's physician's order dated 3/5/2021, the physician's order indicated to administer one tablet Quetiapine Fumarate 25 milligram ([mg] unit of measurement) twice a day by mouth for psychosis manifested by restlessness and agitation. During a review of Resident 23's Medication Administration Record (MAR) for the month of 5/2021, the MAR indicated Resident 23 had been receiving Quetiapine Fumarate 25 mg 1 tablet as ordered. During a review of Resident 23's monthly Medication Regimen Review (MRR) for 4/2021, the MRR did not indicate the identification of drug irregularities when Quetiapine was used for the treatment psychosis with a diagnosis of dementia. During an interview on 5/27/2021 at 3:58 p.m. with the during an interview the Director of Nursing (DON) , the DON stated Resident 23 was admitted from Hospice (care provided during end of life, focusing on comfort) on Quetiapine, and no recommendation was made by their pharmacist. During an attempted interview on 6/1/2021 at 1:15 p.m., attempted to reach the facility's pharmacist by telephone for an interview, however was unsuccessful.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 30840 Based on interview and record review, the facility failed to ensure Resident 23's antipsychotic medication ([Quetiapine] used to reduce or relieve symptoms of psychosis [severe mental disorder in which thought, and emotions are so impaired that contact is lost with external reality]) was evaluated during the monthly Medication Regimen Review (MRR) by the facility's pharmacist consultant to determine the appropriate rationale from Resident 23's physician. This deficient practice had the potential for Resident 23 to experience adverse drugs reactions. Findings: During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was admitted to the facility on [DATE]. Resident 23's diagnoses included dementia (progressive memory loss) and psychosis. During a review of Resident 23's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 3/15/2021 indicated Resident 23 no cognitive impairment (thought process). The MDS indicated Resident 23 required extensive assistance with activities of daily livings ([ADLs] self-care activities performed on a daily basis). The MDS indicated under the Care Area Assessment (CAA) of the MDS, Resident 23 was triggered for psychotropic (drug that affects behavior, mood, thoughts, or perception) drug use requiring frequent assessment from the licensed staff. During a review of Resident 23's physician's order dated 3/5/2021, the physician's order indicated to administer one tablet of Quetiapine Fumarate 25 milligram ([mg] unit of measurement) twice a day by mouth for psychosis manifested by restlessness, and agitation. During a review of Resident 23's Medication Administration Record (MAR) for the month of 5/2021, the MAR indicated Resident 23 received Quetiapine Fumarate 25 mg 1 tablet as ordered. During a review of Resident 23's care plan dated 3/20/2021, the care plan indicated Resident 23 was receiving Quetiapine Fumarate one tablet 25 mg. The goal was for Resident 23 to have no injuries, outbursts and no side effects. The staff's interventions included observing Resident 23's side effects and administer Quetiapine as ordered. During a review of Resident 23's monthly Medication Regimen Review (MRR) for 4/2021, the MRR did not indicate the identification of drug irregularities when Quetiapine was used for the treatment of psychosis when the resident was also diagnosed with dementia. During a review of Resident 23 medical record, the medical record did not indicate documented evidence that a recommendation was requested from the physician for Quetiapine. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/27/2021 at 1:00 p.m. with the Director of Nursing (DON), the Don stated Resident 23's physician while under hospice (care provided towards the end of life, focusing on comfort) prescribed Quetiapine and the medication was continued by the facility upon admission. The DON stated there was no rationale documented for administering Quetiapine in the resident's clinical record.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44088 Based on observation, interview, and record review, the facility failed to follow resident food preferences for one of 21 sampled residents (Resident 61). This deficient practice had the potential for not meeting Resident 61's food plan, nutritional needs, and preferences. Findings: During an observation and concurrent interview with Resident 61 on 5/26/21 9:08 a.m., Resident 61 was observed lying in bed, with her meal tray at the side of her bed. Resident 61 stated she did not get the breakfast she wanted. Resident 61 stated she preferred to have two bowls of cream of wheat, but only got one every day. Resident 61 was observed with one bowl of cream of wheat on her tray. Resident 61's meal ticket indicated the resident was to receive an over easy egg, two pieces of toast with butter and jelly, two pieces of bacon, and two hot cereals every day. During an interview on 5/27/2021 at 1:45 p.m. with the Registered Dietician (RD), the RD stated Resident 61's tray slip should have been followed. The RD stated when the tray slip was not followed regarding the resident's preferences, the resident may become frustrated and feel unhappy. During an interview on 6/1/2021 at 12:20 p.m. with Licensed Vocational Nurse 7, LVN 7 stated licensed staff checked the meal trays for the correct diet, consistencies, allergies, and resident food preferences prior to the distribution of the trays to the residents. LVN 7 stated if residents did not want the food served there was a chance they would not eat it, and the resident would get frustrated and lose weight. During an interview on 6/1/2021 at 3:29 p.m. with the Director of Nursing (DON), the DON stated licensed staff checked the tray with the tray slip to make sure the residents received the correct food. The DON stated if the residents did not get their food preferences, the residents could get frustrated and not eat. During a review of Resident 61's Admission Records, the Admission Records indicated Resident 61 was admitted to the facility on [DATE]. Resident 61's diagnoses included Parkinson's disease (brain disorder that leads to shaking, stiffness, and difficulty with walking, balance, and coordination) and compression fracture of the third lumbar vertebra (broken bone of the lower spine). During a review of Resident 61's Minimum Data Set (MDS), resident assessment and care-screening tools, dated 4/3/2021, the MDS indicated Resident 61 had no cognitive (ability to learn, remember, understand and make decisions) impairment for daily decision making. The MDS indicated Resident 61 required extensive assistance with mobility, transfer, dressing, eating, toilet use and personal hygiene. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 61's care plan dated 3/29/2021, the care plan indicated the staff's interventions included to monitor Resident 61's food preferences through conversations and provide preferences as often as possible within diet guidelines.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44055 Based on observation, interview, and record review, the facility failed to ensure tomato soup prepared for lunch and dinner was served within four hours of the time it was cooked for 41 of 102 residents (Residents 22, 91, 30, 84, 9, 25, 75, 45, 70, 67, 46, 80, 57, 52, 94, 18, 32, 35, 17, 303, 81, 24, 100, 40, 64, 68, 60, 12, 88,73, 38, 2, 93, 47, 99, 71, 27, 87, 56, 95, and 43). This deficient practice had the potential to result in diminished nutritive value of the food served to the residents. Findings: During an observation and concurrent interview on 5/25/2021 at 11:00 a.m. with Cook 1, tomato soup was observed in the warmer on the stove and the temperature was set at 180 Fahrenheit. Cook 1 stated the tomato soup was cooked an hour prior and was placed in the warmer. During an interview and concurrent record review on 5/27/2021 at 11:50 a.m. with Cook 1, Cook 1 stated on 5/25/2021, tomato soup was served at lunch time for those residents who requested it and was again served at 4:30 p.m. as a dinner menu item as indicated on the menu. During an interview on 5/27/2021 at 11:55 a.m. with the Dietary Service Supervisor (DSS), the DSS stated food placed in the warmer can only stay in the warmer for a maximum of two hours. The DSS stated anytime beyond two hours for extended periods in the warmer resulted in compromised quality of the food. The DDS stated they did not have a policy on food holding. During a review of the diet profile cards of residents who were served tomato soup for dinner on 5/25/2021, the diet profile cards indicated 41 residents received tomato soup as part of their entree. During a review of an undated tomato soup recipe titled, SOUP Recipe #1930, the SOUP Recipe #1930 indicated maximum holding time of the tomato soup was four hours.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview, and record review, the facility failed to prepare food under safe conditions and follow proper infection control guidelines by not ensuring: 1. Undercooked, unpasteurized (process used to destroy bacteria and reduce the risk of food-borne illnesses in dishes that are not cooked or lightly cooked) eggs were not served to six of 102 residents (Residents 8, 9, 33, 61, 71, and 76). 2. Kitchen staff correctly wore a face mask while working in the food preparation area. These deficient practices had the potential to result in the contamination of food that can cause a foodborne illness outbreak. Findings: a. During the facility kitchen tour on 5/25/2021 at 10:40 a.m., the eggs did not have a P stamped on the shells indicating they were pasteurized. During an observation and concurrent interview with Cook 1 and the Dietary Aide (DA) on 5/26/2021 at 7:04 a.m., the eggs in the refrigerator were observed without a P stamped on the shells. Cook 1 stated the eggs were used for fried eggs. The DA confirmed their was no P stamped on the eggs. There were six (6) fried eggs observed on the steam table. During an observation and concurrent interview with Resident 76 and Certified Nursing Assistant/Restorative Nurse Assistant (CNA/RNA 1) on 5/26/2021 at 7:14 a.m., Resident 76 stated he liked his eggs runny and over easy and stated he had one every day. CNA/RNA 1 stated the eggs were a little runny. During an interview on 5/26/2021 at 7:15 a.m. with Cook 1, Cook 1 stated Resident 33 requested sunny-side up eggs. Cook 1 stated sunny-side up eggs were cooked where we do not flip to the other side. During an observation on 5/26/2021 at 7:50 a.m., the packaging for the eggs indicated the eggs were Grade A, large, white, and cage free. The packaging did not specify that the eggs were pasteurized. The safe handling instructions indicated, To prevent illness from bacteria: keep eggs refrigerated, cook eggs until yolks are firm, and cook foods congaing eggs thoroughly. During an observation and concurrent interview on 5/26/2021 at 9:40 a.m. with Resident 61, Resident 61 stated she liked her eggs runny. Resident 61 was observed slicing her eggs to show the liquid egg yolk and then ate the eggs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review on 5/26/2021 9:49 a.m. with the Dietary Supervisor (DS), the DS submitted the diet profiles for Residents 8, 9, 33, 61, 71, and 76, who were served with sunny-side up or over-easy eggs. The DS stated the facility removed all the unpasteurized eggs from the facility. The DS stated using unpasteurized eggs can cause illness if undercooked because it might cause salmonella (an infection caused by contaminated food or water). During an observation on 5/27/2021 at 8:00 a.m., pasteurized eggs were observed in Refrigerator F. The eggs had a P stamped on the shells and the eggs packaging indicated that the eggs were pasteurized. During an interview on 5/27/2021 at 10:28 a.m. with Cook 1 and the DS, Cook 1 stated they were in-serviced not to serve unpasteurized eggs. Cook 1 stated he had been an employee of the facility for [AGE] years and they have always used unpasteurized eggs. The DS stated there were no records of past in-services about unpasteurized eggs. During an interview on 5/27/21 at 11:10 a.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated eating undercooked eggs that was not pasteurized could cause severe illness. During an interview on 5/27/2021 at 1:30 p.m. the Dietician, the Dietician stated she was not aware they had been using unpasteurized eggs in the kitchen. The Dietician stated that consuming undercooked unpasteurized egg could result in illness. During a review of the Centers for Medicare and Medicaid Services, Survey and Certifications (CMS S&C) letter 14-34 dated 3/20/2014, the CMS S&C letter indicated skilled nursing and nursing facilities should use pasteurized shell eggs or liquid pasteurized eggs to eliminate the risk of residents contracting Salmonella Enteritis (SE). The CMS S&C letter indicated in accordance with the Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA) standards, skilled nursing and nursing facilities should not prepare nor serve soft-cooked, undercooked or sunny-side up eggs from unpasteurized eggs. Per Food and Drug Administration web site (www.fda.gov), content current as of 4/6/2020: Egg-associated illness caused by salmonella is a serious public health problem. Infected individuals may suffer mild to severe gastrointestinal illness, short term or chronic arthritis, or even death. Implementing the preventive measures would reduce the number of SE infections from eggs by nearly 60 percent. b. During an observation and concurrent interview on 5/25/2021 at 10:50 a.m. with Kitchen Staff 1 (KS 1), KS 1 was observed wearing a surgical mask that was covering only her mouth, leaving her nose uncovered. KS 1 stated, It keeps falling off. During an observation on 5/25/2021 at 11:10 a.m., KS 1's mask was observed down below her nose and only covering her mouth. During an observation and concurrent interview on 5/27/21 at 10:54 a.m., KS 1's mask was observed over her mouth leaving her nose uncovered. KS 1 stated she was so busy she failed to realize that her mask dropped below her nose. KS 1 stated masks were supposed to be worn all the time in the kitchen or facility except when eating to protect from COVID-19 (a highly contagious infection, caused by a virus that can easily spread from person to person). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's COVID-19 Mitigation Plan Manual, dated 6/10/2020, the manual indicated all staff had to wear a facemask while in the facility for source control. According to the Los Angeles County Department of Public Health website at http://publichealth.lacounty.gov/acd/ncorona2019/healthfacilities/snf/prevention/#InfectionPrevention, Coronavirus Disease 2019 Guidelines for Preventing & Managing [NAME]-19 in Skilled Nursing Facilities, updated 4-11-21, it indicated staff should wear a medical-grade surgical/procedure mask or respirator for universal source control at all times while they are in the facility.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview, and record review, the facility failed to ensure food stored in one of 21 sampled residents (Resident 33) personal refrigerator was labeled, dated, and monitored. This deficient practice had the potential for food contamination and food borne illnesses. Findings: During a review of Resident's 33 Admission Record (Face sheet), the Admission Record indicated the resident was admitted to the facility on [DATE]. Resident 33's diagnoses included toxic encephalopathy (brain malfunctions caused by toxins on the brain), heart failure (condition in which the heart can not pump enough blood to meet the body's needs), atrial fibrillation (an irregular and often rapid heart rate), hyperlipidemia (high levels of fat particles [lipids] in the blood), cardiomegaly (abnormal enlargement of the heart), and dementia (progressive impairments to memory, thinking and behavior, that affect the ability to perform everyday activities). During a review of Resident's 33's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 3/12/21, the MDS indicated Resident 33 was sometimes understood by others and sometimes understands others. The MDS indicated Resident 33 required total to extensive assistance with activities of daily living ([ADL's] daily self-care activities such as bathing, grooming, eating, and toileting). During an interview on 5/25/21 at 12:32 p.m. with Certified Nursing Assistant 9 (CNA 9), CNA 9 stated Resident 33's family member comes and brings food for the resident. CNA 9 stated housekeeping staff was responsible for cleaning the resident's refrigerators and assumed it was cleaned daily. During an observation and concurrent interview on 5/25/21 at 12:45 p.m. with Licensed Vocational Nurse 10 (LVN 10), LVN 10 stated housekeeping was responsible for cleaning the refrigerator and stated that it is used for drinks only. LVN 10 opened Resident 33's refrigerator and observed unopened raw foods and food brought from the outside with no label, no date and no log for monitoring when it was cleaned by the housekeeping staff. During an interview on 5/27/21 at 11:04 a.m. with Housekeeper 1 (HK 1), HK 1 stated she was responsible for cleaning Resident 33's personal refrigerator. During a review of the facility's policy and procedure (P/P) titled, Foods brought by family/visitors, revised 4/2017, the P/P indicated perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. The P/P indicated containers will be labeled with the resident's name, the item, and the use by date.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30840 Based on observation, interview, and record review, the facility failed to ensure a change of condition (COC) was documented for two of 21 sampled residents (Residents 44 and 84). This deficient practice had the potential to result in Residents 44 and 84 to not receive appropriate care and treatment. Findings: a. During a review of Resident 44's Admission Record (Face Sheet), the Admission Record indicated Resident 44 was admitted to the facility on [DATE]. Resident 44's diagnoses included dysphagia (difficulty of swallowing), abnormalities of gait and mobility, dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), encephalopathy (a disease in which the functioning of the brain is affected that alters brain function or structure) and urinary tract infection ([UTI] an infection in any part of your urinary system - your kidneys, ureters, bladder and urethra). During a review of Resident 44's Minimum Data Set (MDS), a resident assessment and care-planning tool, dated 3/19/2021, the MDS indicated Resident 44 had severe cognitive (thought process) impairment. During an observation on 5/27/2021 at 8:11 a.m., Resident 44 was observed with a skin tear (when a layer of the skin separates or peels back) on the left shin area. During an observation and concurrent interview on 5/27/2021 at 8:26 a.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated she was not informed and did not know there was a skin tear on Resident 44's left shin. LVN 3 assessed Resident 44's left shin and confirmed there was a skin tear observed. LVN 3 stated it was a quality of care issue, even if Resident 44 cannot speak but the resident could feel even if the resident cannot verbalize. LVN 3 stated she would notify Resident 44's physician of the change of condition (COC). During an interview and concurrent record review on 5/27/2021 at 8:41 a.m. with LVN 3, LVN 3 confirmed there was no documentation for any COC regarding Resident 44's skin breakdown on the left shin. During an interview on 5/27/2021 at 11:03 a.m., with Restorative Nurse Assistant 1 (RNA 1), RNA 1 stated she did not see the skin tear on Resident 44's left shin yesterday (5/26/2021) when she (RNA 1) provided care to Resident 44. During an interview on 5/27/2021 at 11:26 a.m. with LVN 2, LVN 2 stated if the assigned staff did not inform her for any COC to a resident, she would never know, LVN 2 stated it was everybody's responsibility to check the resident and provide an assessment from head every shift while providing care to the resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 84's Admission Record (Face Sheet), the Admission Record indicated Resident 84 was admitted to the facility on [DATE]. Resident 44's diagnoses included dysphagia, encephalopathy, cerebral ischemia (condition in which a blockage in an artery restricts the delivery of oxygen-rich blood to the brain, resulting in damage to brain tissue), acute respiratory failure (occurs when fluid builds up in the air sacs in your lung), and anemia (condition in which the blood doesn't have enough healthy red blood cells). During a review of Resident 84's MDS, dated [DATE], the MDS indicated Resident 84 had severe cognitive impairment. During an observation on 5/25/2021 at 10:13 a.m., Resident 84 was observed with a skin tear and blood clots inside the left ear area. During an interview on 5/26/2021 at 8:06 a.m. with LVN 2, LVN 2 stated all assigned staff to Resident 84 who provide care should be able to see the resident's skin tear, including the charge nurse who administers medication. During an interview on 5/26/2021 at 8:09 a.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated when CNA's provide care to the residents, they also must check for any new changes like skin breakdown and report the COC to the charge nurse. During an interview and concurrent record review on 5/27/2021 at 8:58 a.m. with LVN 3, LVN 3 stated staff should have captured Resident 84's left ear skin tear because it can be easily seen. LVN 3 stated the assigned staff should have reported it to the charge nurse or the treatment nurse, and a skin assessment should have been done. LVN 3 verified there was no documentation for skin breakdown on Resident 84's left ear. During an interview on 5/28/2021 at 11:26 a.m. with LVN 2, LVN 2 stated it was everyone's responsibility to make sure all assigned staff should provide resident assessments from head to toe every shift. During a review of the facility's policy and procedure (P/P) titled, Change in Resident's Condition or Status, revised on 8/2017, the P/P indicated the facility shall notify the resident, his or her Attending Physician, and Responsible party of changes in the resident's medical/mental condition and/or status. The P/P indicated the Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. The P/P indicated a significant change of condition is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting) including: 1. Open or red areas. 2. Bruises, lacerations, blisters, rashes, or skin tears.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 41699 Based on interview and record review, the facility failed to employ a qualified social worker on a full-time basis that met the qualifications specified in the regulation. This deficient practice had a potential for 102 of 102 residents residing in the facility to not be assisted and receive medically-related necessary care to attain their highest practicable well-being. Findings: During an interview on 5/27/2021 at 11:56 a.m. with the Social Services Director (SSD) designee (SSD 1), SSD 1 stated the previous SSD resigned back in October of 2020 and was replaced by another SSD designee but they also resigned on May 7, 2021. SSD 1 stated, I am the acting SSD, this facility is licensed for 156 residents and we all know that we need a full-time SSD to be employed. SSD 1 stated she has not applied for the position because she did not have a bachelor's degree and was not qualified to be a SSD. SSD 1 stated if this facility is under 120 beds, she will be qualified. During an interview on 5/27/2021 at 12:34 p.m. with the Director of Nursing (DON), the DON stated the facility's SSD must have a bachelor's degree because of the size of the facility and the ability of the facility to handle more than 120 residents. During an interview on 5/27/2021 at 12:38 p.m. with the Administrator (ADMIN), the ADMIN stated because the facility was licensed to more than 120 residents, the SSD candidate must have a bachelor's degree of psychology or any sciences related to social services. During a review of the job description for Director of Social Services, revised 10/2019, the job description indicated: Under the direction of the SNF Administrator, the Director of Social Services job position is to plan, develop, organize, and direct the overall operation of our facility's Social Services Department in accordance with current federal, state and local standards, guidelines and regulations, our established policies and procedures, and as may be directed by the Administrator, to assure that the medically related, emotional, and social needs of the resident are met/maintained on an individual basis. The Director of Social Services is delegated the administrative authority, responsibility, and accountability necessary for carrying out the assigned duties.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 41699 Based on interview and record review, the facility's Quality Assessment and Assurance (QAA) and Quality Assurance Performance Improvement (QAPI) committee failed to: 1. Employ a qualified social worker on a full-time basis that met the qualifications specified in the regulation. 2. Evaluate the provisions of care and develop a policy and procedure for hiring a full-time Social Services Director. 3. Monitor the alcohol consumption and documented any adverse reaction with medication in the resident's Medication Administration Record (MAR) for Resident 33. 4. Assess and care plan Resident 33's self- administration of alcohol. 5. Evaluate the provisions of care and develop a policy and procedure for routinely checking residents consuming alcohol. 6. Ensure the Pharmacist Consultant reviewed, documented, and reported any irregularities with Resident 33's drug regimen for any adverse reaction with alcohol consumption. Theses deficient practice had a potential for 102 of 102 residents residing in the facility to not be assisted and receive medically related necessary care, and had the potential for alcohol medication interactions which included dizziness, drowsiness, impaired thinking, judgement, and motor coordination and placed Resident 33 at risk for injury. Findings: During an interview on 6/1/2021 at 11:44 a.m. with the Administrator (ADMIN), the ADMIN stated he was aware the facility must hire a full-time SSD but was not successful in finding one. The ADMIN stated he was not aware there was a resident consuming alcoholic beverages and there was no staff who was monitoring the alcoholic consumption and its interactions with the resident's drug regimen. There was no safety measures in place to prevent other residents and staff from accessing the alcohol. During a review of the facility's policy and procedure (P/P) titled, Quality Assurance and Performance Improvement (QAPI) Plan, revised 4/2014, indicated the facility shall develop, implement, and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by: Ensuring staff used appropriate personal protective equipment ([PPE] protective clothing, garments or equipment designed to protect the wearer or the resident from infections) before entering a room in the yellow zone (designated isolation area for residents who are under the suspicion for COVID-19 [a potentially severe respiratory illness caused by a coronavirus and characterized by fever, coughing, and shortness of breath]). This failure placed all the residents, staff, and the community at higher risk for cross-contamination, and increased spread of COVID-19 infection in the facility and the community. Findings: a. During an observation on 5/25/2021 at 1:06 p.m., Certified Nursing Assistant 3 (CNA 3) was observed entering room [ROOM NUMBER], a designated yellow zone room, without wearing the required PPE. During an interview on 5/25/2021 at 1:17 p.m. with CNA 3, CNA 3 stated she knew she had to wear complete PPE when entering a room on the yellow zone for her protection and for the protection of the resident. CNA 3 stated she forgot and that there was no PPE supplies in the isolation cart. During an observation on 5/25/2021 at 1:23 p.m., Housekeeper 1 (HK 1) was observed entering room [ROOM NUMBER], without wearing the required PPE, emptying the trash bin. During an interview on 5/25/2021 at 1:35 p.m. with HK 1, HK 1 stated she should have put on a blue gown but there were no blue gowns available inside the isolation cart. HK 1 stated there was a possibility of spreading the virus or any infection because I'm transporting soiled linens and trash from the isolation room and passing the hallway and carrying it in the elevator. During an interview on 5/26/2021 at 3:36 p.m. with Registered Nurse Quality Assurance (RNQA), RNQA stated when you get to the yellow zone room, the staff must wear the required PPE. RNQA stated if staff did not wear the appropriate PPE, there was the potential to cross-contaminate to other residents. During an interview on 5/27/2021 at 9:09 a.m. with the Infection Preventionist Nurse (IP), the IP stated whichever staff assigned in the isolation/yellow zone room, the staff must be wearing the required PPE before entering the resident's room and remove the used gown and gloves before exiting the yellow zone room. The IP stated it was an infection control issue if the staff did not follow proper infection control protocol. The IP stated the housekeeping and laundry personnel must do the same practice as the rest of the staff. The IP stated everybody must be doing the acceptable infection control practices to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P/P) titled, Infection Prevention and Control Program, revised 3/2020, the P/P indicated infection control and prevention is the name given to a wide range of policies, procedures and techniques intended to prevent the spread of infectious diseases amongst staff and service users. The P/P indicated all of the staff working at the facility are at risk of infection or of spreading infection, especially if their role brings them into contact with blood or bodily fluids like urine, feces, vomit, or sputum. Such substances may well contain pathogens that can be spread if staff do not take adequate precautions. The P/P indicated adherence to strict guidelines on infection control is of paramount importance in ensuring the safety of both service users and staff, and that good, basic hygiene is the most powerful weapon against infection, particularly with respect to hand washing. b. During an observation on 5/26/21 at 9:45 a.m., Licensed Vocational Nurse 5 (LVN 5) as observed standing in front of room [ROOM NUMBER]. Signage was observed at the entrance of room [ROOM NUMBER] indicating it was a yellow zone room and PPE supplies were located in front of the room in the designated PPE cart. The signage indicated the PPE was needed prior to room entry, which included an N-95 (type of mask), an isolation gown, a face shield or goggles, and gloves. LVN 5 was observed preparing Resident 86's medications at her medication cart prior to entering the room. During an observation on 5/26/2021 at 9:50 a.m., LVN 5 entered Resident 86's room without donning an isolation gown or gloves. LVN 5 was only wearing a N-95 mask and a face shield. During an observation on 5/26/2021 at 10:00 a.m., LVN 5 was observed at the bedside in close proximity to Resident 86. LVN 5 placed the call light and eye glasses in Resident 86's hands without an isolation gown or gloves on. During an interview on 5/26/2021 at 10:07 a.m., LVN 5 stated she did not put on an isolation gown or gloves because it was acceptable not to do so since LVN 5 was in the room for less than five (5) minutes. During an interview on 5/27/2021 at 8:00 a.m. with the IP, the IP stated Resident 86 was a dialysis (process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally) resident and therefore was placed in yellow zone room per county guidelines. The IP stated Resident 86 was on contact and droplet isolation. The IP stated whoever entered Resident 86's room needed to don (wear)all the required PPE (N-95, isolation gown, face shield or goggles, and gloves) regardless of time spent in the room. The IP stated even if staff anticipated to be in the room less than 5 minutes, staff needed to don the required PPE because we can not predict what would happen once staff entered the room. The IP stated not donning the required PPE increased the risk of spreading infections and COVID-19. During a review of the facility's Infection Prevention and Control Program P/P, dated 5/17/2020, the P/P indicated that a yellow zone room will be treated with contact and droplet precautions. Contact precautions and droplet precautions require the donning of an isolation gown, gloves, and a face mask. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Los Angeles County Department of Public Health website at http://publichealth.lacounty.gov/acd/ncorona2019/healthfacilities/snf/prevention/#InfectionPrevention, Coronavirus Disease 2019 Guidelines for Preventing & Managing [NAME]-19 in Skilled Nursing Facilities, updated 4-11-21, it indicated health care providers should follow transmission- based precautions for each cohort including standard precautions and wearing of appropriate PPE. It further indicated: gloves should be changed between every patient encounter; N95 respirators should be worn; eye protection, which is defined as a face shield or goggles, is recommended for close contact with patients (within 6 feet); and gowns should be changed between patients in all cohorts if adequate supplies are available, even in multi-occupancy rooms. 44055