STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056361	A. Building B. Wing	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortuna Rehabilitation and Wellness Center, LP	2321 Newburg Road Fortuna, CA 95540

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32860 Based on observation, interviews, and facility document review, the facility failed to ensure resident's rights were protected for five of 17 sampled residents (Resident 221, 47, 38, 16, and 5) and two confidential residents when: 1. Facility did not provide assistive devices to Resident 221 to maintain correct position after a surgery and activity items to dull or distract from the noise level in the facility, which resulted in Resident 221 suffering from the terrorizing noise level and not receiving a grabber (picker-upper) to avoid bending; 2. Staff did not respond to call lights in a timely manner, which resulted in a) residents not receiving assistance or care timely, b) Resident 221 urinating on herself, being humiliated, falling on her own urine, and requesting early discharge because she was in fear for her life, and c) Resident 16 feeling bad and embarrassed beyond words; 3. Staff did not assess or educate Resident 47 on call light use, which resulted in Resident 47 not being able to use the call light for assistance, potentially causing falls, injuries, or embarrassment; and 4. Staff did not assist Resident 5 and 38 for meals, which resulted in residents having difficulty in feeding themselves, spilling food over their clothing, and not being positioned properly for meals. These failures had negatively impacted residents' psychosocial well-being and quality of life. Findings: 1-2. During an interview on 3/6/18 at 10:00 a.m., Resident 221 (post-op right hip arthroplasty, a surgical procedure to restore joint functions) stated she left the facility prior to end of insurance coverage because she felt her life was in danger. Resident 221 stated the facility housed a majority of seniors who could not care for themselves, but were not taken care of by the staff. Many of the wheelchair residents had alarms on their wheelchairs. When they moved, or stood, these alarms went off, but no staff came to address the alarms, or check on the residents. The noise level was terrorizing. (continued on next page)

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Resident 221 stated she witnessed other residents fall, and fell herself one night. When asked how she fell , Resident 221 stated she needed to go to the bathroom, and placed the call light on, no staff answered the call light, so she got up out of bed. After getting up, Resident 221 stated that she could not see a path to get to the bathroom and urinated on herself. Resident 221 stated she was humiliated, but knew she needed to get back to bed. In the time that passed, no one came to answer her call light. Resident 221 stated on attempt to get back to bed she fell in her own urine, but no one came to help get her back to bed. Resident 221 stated she got back to bed without the help of staff. When a staff member did come into the room, Resident 221 stated she told them about the fall, and having urinated on the floor. Resident 221 stated the staff member made a comment to her that housekeeping did not arrive until 6 a.m. Resident 221 asked for a grabber (picker-upper) to avoid bending, ear plugs and a radio to try to drown out the noise, none of the requests were honored. Resident 221 stated she had a prescription for a marijuana pin from her surgeon. Resident 221 stated the facility staff took the Marijuana pin from among her belongings while she was out of the room. Resident 221 stated the head nurse came to her and stated that facility had confiscated the marijuana pin, called Family 2 to pick up the marijuana pin, and planned to release it to him. Resident 221 stated despite her insistence that she had a prescription for the marijuana pin, she was told it was illegal to have it in the facility. Resident 221 stated they went into my room and took my stuff .Isn't that theft. During an interview on 3/7/18 at 8:20 a.m., DON (Director of Nursing) stated No one is allowed to have marijuana, not in my building. One of the aides picked it up from Resident 221's bedside table and brought it to me. DON stated that when she was informed it was a Marijuana pin she went directly to Resident 221, who was receiving physical therapy at the time, and told her the facility was confiscating the pin. DON stated she informed Resident 221 that she had telephoned Family 2 to come to pick up the Marijuana pin, and would release the pin to him. When questioned about her method of removing the Marijuana pin while the resident was out of the room, DON stated the former DON would have called the police in this matter. DON stated she did not remember the name of the staff member who brought the Marijuana pin to her. During a concurrent interview and observation on 3/7/18 at 8:34 a.m., of activities supplies was made. A radio was observed and Activities Director stated the radio was one of two that belonged to the facility. When asked about ear plugs. Activities Director stated the previous activity director must have ordered them because she recently threw out a box of them. Activities Director stated she did not remember any resident asking for ear plugs. During an interview on 3/7/18 at 8:42 a.m., Rehabilitation Director stated the facility kept a supply of grabbers/picker-uppers, to assist any resident who needs one. Rehabilitation Director stated that in the event the supply is depleted and a resident asked for a grabber, the rehabilitation staff taught strategies to safely obtain items until the equipment was replaced. Replacement took 2 to 3 days. During a review of the clinical record for Resident 221, the Physicians Progress Note dated, 12/9/17, indicated: .Multiple intolerances of medications/opiates trial suboxone (a medication for pain) 1-2 mg (milligram). lots of questions/ long story of previous history/current condition. Complaint fell attempting to get to BR(bathroom)-3 days ago. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	During a review of the clinical record for Resident 221, the Interdisciplinary Team Conference Record dated, 12/11/17, indicated: .On Friday 12/8/17 resident was in possession on her over head table while out of room in Therapy of a cannabis pen which was brought to DON for safety .Resident stated, my doctor said I could use it. Pen was secured .Son was irate because pen was taken from her .Resident has hip precautions and is claiming she has fallen and got herself up without witnesses present .Resident requested pharmacist to discuss medications .then claimed he wanted to see her vagina .Therapy gave resident a shower Wednesday, Friday, CNA (Certified Nursing Assistant) reports 2 additional showers on Sunday and is demanding another shower today (Monday) . During a review of the clinical record for Resident 221, the MDS (Minimum Data Set) dated, 12/08/17, indicated: Brief Interview for Mental Status score of 15, which indicates alert and oriented. During a review of the clinical record for Resident 221, the History and Physical from local hospital dated, 11/21/17, indicated: Medications: 1. Ibuprofen as needed. 2. Medical Marijuana. 3. Meloxicam 4. Voltaren. During a review of the clinical record for Resident 221, the Resident [NAME] of Rights dated, 5/11, indicated: .7. To be encouraged and assisted throughout the period of stay to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal .12. To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs . 16. To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients. During an interview on 3/7/18 at 8:20 a.m., DON was asked for a policy and procedure for Medical Marijuana and she stated the facility did not have one. 37160 2a. During an initial pool sample selection interview, on 2/26/18, at 9:06 a.m., Resident 16 stated, they're always short with people. Resident 16 stated she had to wait up to an hour before staff would answer the call light because they did not have the help you need. Resident 16 stated, If you can't get into the toilet, it's bad, you have to do it in your pants. No words to describe it. Put yourself where you're laying and you can't move. You have to go; you're trying to hold it. You're embarrassed. Resident 16 stated if you were already sitting in the toilet, you have to wait until someone comes. During a review of the clinical record for Resident 16, the Minimum Data Set (Resident assessment tool) dated 12/11/7, indicated Resident 16 needed an extensive assistance (resident involved in activity, staff provide weight-bearing support) with transfer and toileting. 32961 2b. During a confidential group interview on 2/27/18, at 11:30 a.m., regarding call light wait time, one of nine attended residents stated sometimes he had to wait for a long time. Another resident stated it depended on what they needed. The resident stated one CNA (certified nursing assistant) per hall, some CNAs helped, but some would not. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	3. During a concurrent observation and interview on 2/26/18, at 8:32 a.m., in Resident 47's room, Resident 47 stated he needed help to open the window curtain. Resident 47 squeezed the call bell (a ball like call bell) a total of five times, but the call light was not on. Resident 47 stated he could not move his right arm and hand, so he used his left hand to squeeze the call bell. Unlicensed Staff C walked by the hallway and was called into Resident 47's room. Unlicensed Staff C stated Resident 47 might have not pressed the call bell hard enough. Unlicensed Staff C opened the window curtain for Resident 47. Unlicensed Staff C did not assess or educate Resident 47 on call bell use. Resident 47's MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 2/1/18, revealed Resident 47's BIMS (brief interview for mental status) score was 15, which indicated Resident 47 was cognitively intact. During a concurrent observation and interview on 3/1/18, at 9:57 a.m., in Resident 47's room with Licensed Staff D regarding the call bell, Resident 47 squeezed multiple times and squeezed hard that the call bell (a ball like call bell) was dented, but the call light was not on. Resident 47 stated he would like to use the call bell for assistance. Licensed staff D tested the call bell and call light was on. Licensed Staff D stated the call bell was working, but Resident 47 was not able to use it correctly due to lack of hand coordination. The Maintenance Director came in and tested the call bell. The Maintenance Director stated he had to press down the call bell quickly to make it work. He stated if the resident pressed down slowly, it would not work. During an interview on 3/1/18, at 10:10 a.m., Licensed Staff D stated Resident 47 could use the call bell, but she did not know when his last time used the call bell. When asked how would Resident 47 able to get help when staff was not in his room, Licensed Staff D stated Resident 47 would called out loud, which could be heard in the nurse station. Licensed Staff D stated Unlicensed Staff C should have reported to her (Licensed Staff D) and she should have reported to the Maintenance Director to change the right type of call bell for Resident 47. Licensed Staff D stated they had a few different types of call bell. Upon request for facility policy and procedure, the facility provided the Resident [NAME] of Right, dated 05/11, indicated .Patients shall have the right .to be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs . 35842 4a. During an observation on 2/26/18 at 1:15 p.m., Resident 5 was in bed in a light weight hospital gown, which was not tied and caused her upper chest to be fully exposed. Resident 5 was positioned at approximately a 45 degree angle for lunch. Resident 5 was on a puree diet, which was over her bed, but no one was assisting Resident 5 with her meal and food particles were all over her. No straw was in her glass per physician's order. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 2/28/18 at 2:10 p.m., Resident 5 was feeding herself a pureed diet. Resident 5's was positioned at a 45-degree angle while eating, napkin was not in place and food was all over Resident 5's clothes and blankets. There was no staff supervising Resident 5 while she was eating her meal. Resident 5's breathing sounded a little raspy after meal. Licensed Staff H stated Resident 5 did need assistance. Licensed Staff H stated Resident 5 did have a bib, but she had pulled it off and it was under her covers. Licensed Staff H stated the certified nursing assistant (CNA) would go between Resident 5 and Resident 38, but there was not enough staff to assist residents who were eating in their room and in the assisted dining room at the same time. Licensed Staff H stated the CNAs assisted the residents in the assisted dining room first and then the residents who wanted to eat in their room. A review of Resident 5's Physician Orders, dated 12/12/16, and Medication Administration Records (MAR), dated 1/18 and 2/18, indicated Resident 5 was on swallowing precautions and needed a straw for thin liquids. Resident 5's Annual MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 12/5/17, indicated Resident 5's cognitive skills for daily decision making was severely impaired (never/rarely made decision), the range of motion of upper right extremity (limb) and both lower extremities were impaired, and Resident 5 had a swallowing disorder: loss of liquids/solids from the mouth when eating or swallowing. During an interview on 3/06/18 at 3:37 p.m., Licensed Staff BB was asked why Resident 5's Quarterly MDS for 9/5/17 and Annual MDS for 12/5/17 ADLs (Activities of Daily Living) for eating indicated Resident 5 was a Set-up Help Only when Resident 5's Resident Care Plan - Nutrition -Swallowing, indicated Resident 5's swallowing interventions included staff to monitor Resident 5 for signs and symptoms of aspiration: shortness of breath, wheezing (whistling sound produced in the respiratory airways during breathing), coughing ., instruct resident to swallow after each bite, instruct/cue resident to chin tuck (tip head forward), and elevate head of bed minimum of 90 degrees during meals and for 30 minutes after, etc. Licensed Staff BB stated Resident 5's MDS should have been coded as One Person Assistant. When asked what she looked at before coding, Licensed Staff BB stated she reviewed the resident's medical records including the physician's History and Physical, Nurse's Progress Notes, and Medication Administration Record, and talked to nursing staff and to the resident, if they were able to communicate A review of Resident 5's Resident Care Plan - Nutrition-Swallowing Impairment, dated 12/17/18, indicated swallowing interventions included monitor for signs and symptoms of aspiration: shortness of breath, wheezing (whistling sound produced in the respiratory airways during breathing), coughing ., instruct resident to swallow after each bite, instruct/cue resident to chin tuck (tip head forward), and elevate head of bed minimum of 90 degrees during meals and for 30 minutes after. These care plan interventions were not being followed. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	4b. During an observation on 2/26/18 at 1:19 p.m. Resident 38 was eating her pureed lunch unassisted in bed. Resident 38 was positioned at a 45 degree angle and leaning to the right side. Resident 38's overbed table was positioned to the side of the bed, so Resident 38 could not reach her tray. Resident 38's plate of pureed beans and taco casserole was uncovered and no one came to assist her. Resident 38 was holding a bowl of pureed food and was scooping the food out with her hand. Resident 38 was still in her hospital gown and there was food all over her chest. Resident 38 did have a sipping cup, but she also had a non-adaptive glass filled to the top and out of reach. During an observation on 2/28/18 at 1:55 p.m., Resident 38 was having her lunch in bed unassisted. Resident 38 was holding her sipping cup and trying to drink from it, but she was having difficulty bring the cup to her mouth. Resident 38 had no napkin on her and milk was dripping all over her. Resident 38's pureed lunch tray was on her overbed table, but Resident 38 had slid down in the bed and could not reach her lunch tray. During a concurrent observation and interview on 2/28/18 at 2:00 p.m., Licensed Staff H was asked to see Resident 38's position in bed as Resident 38 attempted to feed herself lunch. Licensed Staff H stated Resident 38 was not positioned correctly in bed for lunch in order for Resident 38 to reach her meal tray. Licensed Staff H stated Resident 38 was down to low in the bed. Licensed Staff H stated Resident 38's daughter had requested Resident 38 attempt to feed herself first. Licensed Staff H stated Resident 38 did use her fingers to feed herself and Resident 38's daughter was aware. Licensed Staff H stated Resident 38 should have been assisted with her lunch, but the CNA had to assist the residences in the assisted dining room first and then assist the residences eating in their room. Resident 38 was trying to feed her stuffed monkey the sipping cup full of milk. During an interview on 3/7/18 at 8:45 a.m., Confidential X stated the facility knew Resident 38 was total care and needed assistance with eating. Confidential X stated she/he never said it was okay for Resident 38 to use her fingers to scoop out food from a bowl. Confidential X was very upset and sounded very sad because she/he did not live near the facility and was relying on the staff to take good care of Resident 38. Confidential X stated Resident 38 was a total assist. Confidential X stated Resident 38 had severe dementia, so one did not know from one minute to the next if Resident 38 could feed herself or needed to be assisted. Confidential X stated someone really needed to supervise Resident 38 with her meals. Confidential X stated Resident 38 needed total assistance with hygiene, positioning, meals Confidential X stated Resident 38 could not even turn herself. During an interview on 3/7/18 at 9:15 a.m., DON stated Resident 38 should have been positioned upright for her meals, but Resident 38's daughter wanted her to be independent with her meals as much as possible. DON stated it would be better if Resident 38 could have finger foods, but she was on a pureed diet. DON was asked if she thought there was a dignity/safety issue regarding Resident 38 using her fingers to scoop pureed food out of a bowl. DON stated the CNA did make rounds to see if Resident 38 was okay with feeding herself. DON did not see a dignity issue with Resident 38 scooping food out of a bowl with her fingers. DON did not see a safety issue with Resident 38 eating her meals unassisted even after it was brought to her attention Resident 38 had been trying to eat her lunch unassisted on 2/26/18 while positioned at a 45 degree angle, Resident 38's plate had been uncovered, but her overbed table was out of reach, no CNA was in the hallway because the CNAs were in the assisted dining room assisting residents, and Resident 38 was care planned for needing Total Meal Assist. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Resident 38's Admission MDS, dated [DATE], indicated Resident 38's cognitive skills for daily decision making was severely impaired (never/rarely made decision), and Resident 38 had a swallowing disorder: loss of liquids/solids from the mouth when eating or swallowing. A review of Resident 38's Resident Care Plan - Activities of Daily Living, dated 1/11/18 and Resident Care Plan - Nutrition and Hydration, dated 1/15/18, indicated Resident 38 needed assistance with eating and bed mobility, decreased food intake, history of weight loss, dysphagia, cognitive impairment, and decreased feeding skills. Interventions for Resident 38 included total meal assist, encourage sipping cup, offer fluids frequently, and encourage oral fluids and eating at each meal. Total meal assist was not occurring.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 37160 Based on interview and record review, the facility did not follow policy for Physician Orders for Life-Sustaining Treatment (or POLST) (a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration POLST) for one out of seventeen residents (Resident 9) when the facility had no evidence the POLST was discussed with Resident 9's representative. This failure had the potential for violating Resident 9's treatment wishes. Findings: During a limited record review on 2/27/18, at 9:34 a.m., Resident 9's POLST indicated a treatment plant of Do Not Attempt Resuscitation/DNR (Allow Natural Death and Medical Interventions: Limited Additional Interventions. The Physician signed the POLST form on 2/9/18. The POLST form had no signature from Resident 9 and/or resident representative. During an interview and concurrent record review on 3/06/18, at 4:02 p.m., Social Service stated the POLST is offered/reviewed with resident and/or resident representative during initial care conference. The resident and/or resident representative could fill out POLST form if they wanted to have a POLST. The physician would then sign the POLST form. Social Service verified that Resident 9's POLST form had signature from the physician and no signature from resident representative, the Humboldt Public Guardian office. Social Service stated, We have no signature from them. During an interview on 3/06/18, at 4:37 p.m., Social Service stated the facility have no document to support the physician and Social Service spoke with Resident 9's guardian. The facility policy and procedure titled Physician Orders for Life Sustaining Treatment (POLST) dated 1/1/16, indicated, Completion of POLST form will reflect a process of careful decision making by the resident, the resident's legally recognized health care decision maker if the resident lacks decision making capacity, and the attending Physician, Physician Assistant or Nurse Practitioner, regarding the resident's medical condition and known treatment references. This policy indicated a Licensed Nurse or Social Service Designee will provide and explain to any resident or the resident's legally recognized health care decision maker who wishes to complete a POLST form and will notify the Attending Physician, Nurse Practitioner or Physician Assistant that the resident wishes to have POLST.

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 32860 32961 35842 Based on observation, interview, and record review, the facility failed to ensure a safe, comfortable, and sanitary environment when: 1. Multiple residents (Resident 23, 24, 25, 29, 36, 62, 50, 66 and eight confidential residents) out of 68 residents complaint of being cold inside the facility for weeks, and the facility did not maintain comfortable facility temperatures ranging from 71 to 81 degrees Fahrenheit (F). On 2/27/28, at 1:47 p.m., due to the facility's failure to provide comfortable facility temperature, the Administrator and Director of Nursing (DON) were verbally notified of the Immediate Jeopardy. The Health Facilities Evaluator Nurses informed the Administrator and the DON of the interviews with residents complaining of being cold and facility thermometer indicating being 60- 69 F. Immediate Jeopardy is a situation in which a provider'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 (Standard Operation Manual, Appendix Q). On 2/28/18, at 11:30 a.m., the facility presented a corrective plan of action, including but not limited to: 1) servicing the boiler system, 2) in-servicing staff to monitor residents for signs and symptoms of being cold, providing warm clothing and extra blankets, offering and assisting with warm beverages to residents. On 2/28/18 11:48 a.m., the Administrator, Area [NAME] President, Quality Assurance Personnel, were notified of substandard quality of care identified and that the facility was on extended survey. Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.10 resident rights that constitute to immediate jeopardy to resident health or safety (level J, K, or L) (Standard Operation Manual, Appendix P). On 3/06/18, at 1:49 p.m., the abatement (lifted) of Immediate Jeopardy occurred in the presence of the Administrator after interviews and observations confirmed the facility implemented the corrective plan of actions. The Administrator understood the facility would continue to complete plan of action to fix the boiler system and ventilation system to maintain comfortable facility temperature without using temporary blowers. 2. Multiple of resident's toilets had sharp rusty bolts anchoring the base of the toilet, caulking missing around the base of the toilet, bathroom brown rubber cove baseboard was marked, chipped, and/or peeling, room [ROOM NUMBER]'s bathroom wall's paint was peeling and light bulbs were burnt out in two resident bathrooms (room [ROOM NUMBER] and 54). (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. Privacy curtain and window drape in room [ROOM NUMBER]B had multiple grayish and brownish/red splatter marks. 4. Bathroom sink and toilet in room [ROOM NUMBER] and 55 were dusty/dirty with hair and multiple particles/substance. 5. room [ROOM NUMBER]C, 52C, 54C, 55 linoleum floor and room [ROOM NUMBER], 54, 55, and 56's bathroom linoleum floor were unkept; dirty with multiple splatter/spots, brown and rusty stains, purplish colored stains, and/or tissue/cotton balls or food particles on floor. 6. Resident 23's electric chair's left arm rest and left back rest upholstery was torn preventing the electric chair from being cleaned and sanitized thoroughly. 7. Resident's belongs were stored on unoccupied made up resident beds. These failures had the potential to cause: 1. Resident's susceptibility to loss of body heat and risk of hypothermia (a medical emergency that occurs when your body loses heat faster than it can produce, causing dangerous low body temperature), or susceptibility to respiratory ailments and colds, 2. Environmental hazards due to sharp surfaces, 3. Cross-contamination and spread the infection among residents, and 4. Negatively impact residents comfort and homelike environment. Findings: 1. During a concurrent observation and interview on 2/26/18, at 8:16 a.m., in Resident 24's room, Resident 24 was eating breakfast in bed. Resident 24 was wearing a gown, and stated she was cold. When asked if she could request extra blanket, she shook her shoulders. Resident 24's MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 1/12/18, revealed Resident 24's BIMS (brief interview for mental status) score was 15, which indicated Resident 24 was cognitively intact. During an interview on 2/26/18 at 9:25 a.m., Resident 36 stated the biggest complaint was being cold. During a concurrent observation and interview on 2/26/18 at 9:30 a.m., Resident 23 (who resided in the same room as Resident 36) was lying in bed and wearing a lightweight nightgown. Resident 23 stated she was very cold. During an interview in the dining room on 2/26/18 at 10:05 a.m., Resident 62 stated that besides getting in and out of the bathroom with his walker, another issue was the temperature. Resident 62 stated, Sometimes at night it can get pretty cold here, and once you get chilled you can't get warm, even with another blanket. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortuna Rehabilitation and Wellness Center, LP	2321 Newburg Road Fortuna, CA 95540

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview in the dining room on 2/27/18 at 8:30 a.m., Resident 29 asked if surveyor had a thermometer. When confirmed, Resident 29 stated, Could you take the temperature in here? The temperature read 67 F. Resident 29 stated, I'm freezing and the furnace has not been working for months . When complaint was made about it, the staff said the furnace was too old to get parts for it .They have given me three blankets for my bed, but I am still cold, especially at night. I think they should just buy a new one. During an observation on 2/27/18 at 8:50 a.m., the wall thermometer at the end of the 40's hall was 66 F. The wall thermometer in the 60's hallway at the end of the hallway read 61 F. During an interview on 2/27/18 at 9 a.m. in the main dining room, 4 confidential residents out of 6 residents stated they were cold despite having blankets over their laps. During a concurrent observation and interview on 2/27/18 at 9:13 a.m., Resident 25 stated she was very cold. Resident 25 said, That is why I have multiple blankets on. Resident 25's room was the last resident room on the right side of Lytle North hallway right near the exit door. The thermometer located on the wall right of the exit door in the Lytle North hallway read 60 F. During a concurrent observation and interview on 2/27/18 at 9:16 a.m., Licensed Staff J was asked to read the thermometer located in Lytle North hallway. Licensed Staff J stated the thermometer read 62 F. Licensed Staff J stated he had heard there were issues with the heat, but maintenance could answer the issue better. During an interview on 2/27/18 at 11:30 a.m., Maintenance Supervisor was asked to provide documentation that the furnace was in working condition. The Administrator overhearing the conversation interrupted and stated, the boilers are working, but our boiler system cannot keep up with the severe weather. The temperatures in the last few weeks have dropped below freezing. Maintenance Supervisor stated, I don't have documentation, but I can show you the boilers are working, and started a tour of the heating system. During a resident council interview on 2/27/18, at 11:30 a.m., four of nine attended residents stated they had been being cold for months. Two residents stated they were told that the hallway temperature were 60, 61, or 67 F. One resident stated the heater was broken for months. The resident stated the facility staff told him that they could not find the parts for replacement because the heater was old. During an observation and concurrent interview on 2/27/18 at 11:40 a.m., Maintenance Supervisor opened the entryway to boiler room in the front hall of the building. There were 2 boilers inside. Maintenance Supervisor stated, these were new boilers, but that one operated at a time and the second was for a back-up in-case the first one failed. The second boiler room was located at the back of the building (in the 60's hall). After entering 2 doors a huge boiler system with cobwebs, rust around pipes, algae on the side of it was observed. An 8.5 by 11 inch sign titled, Boiler Failure Procedure was observed. Maintenance Supervisor stated that the boiler was very old and heated to a certain degree, and then would shut off automatically. Maintenance Supervisor stated that the rooms in the 40's and 60's halls were at the end of the heat system, which caused the temperatures to drop in those areas. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 2/27/18 at 11:50 a.m., Administrator stated the temperatures were maintained in the facility between 64 to 74 F. On 2/27/18 at 11:50 a.m., the facility provided a document, with no title and no date, indicating Procedure 'comfortable and safe temperature' levels means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia or susceptibility to respiratory ailments and colds. Although there are no explicit temperatures standards for facilities certified on or before October 1, 1990, these facilities still must maintain safe and comfortable temperature levels . During an interview on 2/27/18 at 12:05 p.m., Maintenance Supervisor was questioned regarding the sign titled, Boiler Failure Procedure and stated, when the boiler shuts itself off, this is the procedure we use to turn it back on again. During a concurrent observation and interview on 2/27/18 at 1:13 p.m., surveyor went around facility with Maintenance Supervisor to check hall and room temperatures using infrared temperature gun. Lytle Nurse's Station (located central to room [ROOM NUMBER]'s 50's, and 60's hallways) thermometer read 70 F, Lytle North Hall at mid end of hall read 65-66 F, room [ROOM NUMBER] read 67 F, room [ROOM NUMBER] read 66 F, room [ROOM NUMBER] read 65 F (room [ROOM NUMBER] and 48 are last rooms on Lytle North hallway closest to Exit door). Hall Temperature down East Lytle was (Rooms 60 Hall) ranged from 65-67 F. Maintenance Supervisor read the temperature in Lytle [NAME] temperature, by aiming gun at the end of the hallway where the sun was beaming, and it was 69 F. Maintenance Supervisor stated boiler kicked on a lot slower in the summer due to hotter outside, but in the winter the boiler would kick on a lot faster due to colder outside, between 100-120 F. When Maintenance Supervisor was asked the last time the heater unit was serviced, he could not recall and he could not provide the last invoice. When Maintenance Supervisor was asked for temperature logs for the facility, he could not provide the temperature logs. Maintenance Supervisor stated he monitored the room and hall temperatures with the infrared temperature gun every morning by picking random rooms. Maintenance Supervisor could not recall the last time the heating unit was serviced. Maintenance Supervisor had worked at the facility 4 and a half years, but could not recall the last time the heating system had been serviced. Maintenance Supervisor stated the servicing of the heating system had fallen through the cracks. Maintenance Supervisor stated he had never called for the heating system to be service by an outside vendor. Maintenance Supervisor stated the recommendation for the heating unit was for it to be service on an annual basis. Maintenance Supervisor stated he was responsible for the maintenance of the heating system at the facility. On 2/27/18, at 1:47 p.m., the State Health Facilities Nurse Evaluators notified the Administrator and the Director of Nursing (DON) of the Immediate Jeopardy situation. The Administrator stated, Where's the jeopardy? Our system can't handle this cold temperature. During an observation on 2/28/18 at 11:51 a.m., the thermometer at Lytle North hallway read 66 F. During an observation on 2/28/18 at 4:25 p.m., the thermometer located at the end of Lytle East hallway indicated the temperature in the hallway was 68 F. During an interview on 2/28/18 at 4:25 p.m., Resident 25 stated she felt a lot warmer, but she said, I still have a shirt and a warm sweat shirt and two blankets on me. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a concurrent observation and interview on 3/02/18 at 8:50 a.m., Resident 50 was dressed in a lightweight nightgown and had a bed coat over her shoulders. Resident 50 was up in her wheel chair and eating breakfast next to her bed. When Resident 50 (roommate with Resident 50) was asked if she was cold, Resident 50 said, It was cold this morning. Resident 66 was resting in bed. When Resident 66 was asked if she was cold, Resident 66 said, It seemed warmer, but I have a lot more blankets on as well. It was still cold. I asked a Certified Nursing Assistant (CNA) to bring me another blanket. The facility policy and procedure titled Resident Rooms and Environment no date, indicated, Facility staff aim to create a personalized, homelike atmosphere, paying close attention to the following: Comfortable levels of ventilation .Comfortable temperatures . 2. During multiple observations on 2/26/18 from 8:47 a.m. to 12:07 p.m. toilets located in the bathrooms shared by the residents in Rooms 43, 47, 51, 52, and 53 had rusty bolts anchoring the base of the toilets; no toilet bolt caps for the protruding rusty bolts. The protruding bolts anchoring the toilet base in room [ROOM NUMBER] were sticking up 1 inch on both sides. room [ROOM NUMBER]'s left bathroom wall had peeling paint a yard in length. The bathroom brown rubber cove baseboard located in room [ROOM NUMBER], 47 and 56 was marked, chipped, and/or peeling away from the wall. The caulking around the base of the toilets in room [ROOM NUMBER], 47 and 52's bathrooms was missing and/or the linoleum around the base of the toilet was dirty and had rust color stains. The left light bulb was burnt out in room [ROOM NUMBER] and 54's bathroom. During an environment tour on 3/01/18 at 1:00 p.m.: Maintenance Supervisor stated room [ROOM NUMBER]'s bathroom rubber cove baseboard was rotten and needed to be replaced. Maintenance Supervisor stated a lot of the resident's bathroom rubber cove baseboards needed to be replaced, which he was doing gradually, but he is the only maintenance person for the entire facility, so he had to prioritize his work load. Maintenance supervisor stated the caulking around room [ROOM NUMBER]'s bathroom toilet should be reapplied due to it was missing and the linoleum was stained/old and needed to be replaced. Maintenance Supervisor state room [ROOM NUMBER]'s bathroom linoleum had brown stains due to some of the residents had fall mats in the bathroom and if housekeeping mopped the bathroom floor and placed the fall mat back down before the linoleum floor was dry, the fall mat would cause the floor to become stained. Maintenance Supervisor stated room [ROOM NUMBER]'s bathroom rubber cove baseboard was rotten and needed to be replaced. Maintenance Supervisor stated a lot of the rubber cove baseboard in resident's bathrooms were [AGE] years old. Maintenance Supervisor was able to pull the rubber cove baseboard by hand of the wall and the rubber would just crumble. Maintenance Supervisor again stated the rubber cove baseboard was rotten. Maintenance Supervisor stated room [ROOM NUMBER]'s bathroom rubber cove baseboard was rotten and again pulled the baseboard off the wall by hand showing how rotten the baseboard had become. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	When Maintenance Supervisor was asked how he knew when something in a resident's room need to be fixed/tended to, he stated there was a Fixed Book at each of the nurse's station. The staff member would write down the item needed to be tended to in the Fixed Book. Maintenance Supervisor stated he checked the Fixed Book first thing every morning. Maintenance Supervisor stated often the nurse or CNA would just stop him in the hallway to let him know when something needed to be fixed in a resident's room. Maintenance Supervisor state there was also chalkboard in his workshop where staff could write down something needing to be tended to. Maintenance Supervisor stated all the bolts securing the base of the toilets should have caps on them. Maintenance Supervisor stated after he fixed a resident's toilet he just forgot to cap the bolts. Maintenance Supervisor stated the base of the resident's toilets looked a lot nicer with the caps because the area around the bolts would become rusty in color. Bolt caps were missing on the base of the toilets in the bathrooms shared by the residents in room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]'s, which had bolts sticking up 1 inch. Maintenance Supervisor stated the bolts anchoring the toilet in room [ROOM NUMBER]'s bathroom should have been cut and capped. Maintenance Supervisor stated he worked on the toilet and then forgot to cut and cap the bolts; all bolts should be capped. Maintenance Supervisor stated the back base of room [ROOM NUMBER]'s toilet needed to be caulked and the linoleum was rusty in color due to the toilet leaked at times. Maintenance Supervisor stated room [ROOM NUMBER]'s bathroom linoleum needed to be replaced, it was old and had multiple rust colored stains. Maintenance Supervisor stated the left light bulb in room [ROOM NUMBER] and 54's bathroom was burnt out. Maintenance Supervisor stated staff needed to let him know when a light bulb was burnt out because he did not make daily room rounds; he was the only maintenance person for the entire building and did not have time to make daily room rounds. The facility document titled, Maintenance Assistant, undated, indicated maintenance was to ensure: 1. A safe, comfortable, sanitary environment for residents, staff and visitors in accordance with Federal, State and Corporate requirements and 2. Maintains written records and documents of services performed according to Federal, State and Corporate requirements. 3. During an observation on 2/26/18 at 9:59 a.m., room [ROOM NUMBER]B's privacy curtain and window drape had multiple grayish and brownish/red stains. During an observation on 3/02/18 at 8:50 a.m., room [ROOM NUMBER]B's privacy curtain and window drape were dirty with multiple grayish and brownish/red stains. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a concurrent observation and interview on 3/02/18 at 9:00 a.m., when Housekeeping Supervisor was asked about room [ROOM NUMBER]B's privacy curtain and window drape, which surveyor had noticed had been dirty with multiple grayish and brownish/red stains since 2/26/18, Housekeeping Supervisor stated they were both very dirty and needed to be cleaned. When Housekeeping Supervisor was asked if the housekeeper cleaning the resident's room should notice if privacy curtains and/or window drapes needed to be cleaned, Housekeeping Supervisor stated when the housekeepers make their daily cleaning rounds they should have inspected the resident's privacy curtains and window drapes, and have them cleaned as needed. Housekeeping Supervisor stated privacy curtains and window drapes were cleaned as needed; a resident's room was deep cleaned when a resident was transferred out of the room and as needed. Housekeeping Supervisor stated the residents rooms were not routinely deep cleaned monthly; the residents rooms were deep cleaned if needed. Housekeeping Supervisor stated nursing staff should also let housekeeping know when a resident's privacy curtain and/or window drape became dirty, so housekeeping could have the privacy curtain and/or window drape cleaned. Housekeeping Supervisor stated room [ROOM NUMBER]B's privacy curtain and window drape should have been noticed by the nursing staff and housekeeping, and the privacy curtain and window drape should have been cleaned. Housekeeping Supervisor stated department heads made daily resident room rounds and the department heads should have also noticed the dirty privacy curtains and window drapes, and notified housekeeping. Housekeeping Supervisor stated the housekeepers do not have a checklist to go by when they clean a resident's room. Housekeeping Supervisor stated the housekeepers were trained for a couple of days and were instructed on how and what they were to clean. Housekeeping Supervisor stated there was also a learning manual the housekeepers went by to clean the resident's rooms as well. 4. During multiple observations from 9:20 a.m. to 10:14 a.m., room [ROOM NUMBER] and 55 bathroom sink/faucet/knob area and toilet (tank, toilet bowl, and base) was dirty (hair/dust and other substance). During an environment tour on 3/01/18 at 1:00 p.m., Maintenance Supervisor stated room [ROOM NUMBER]'s bathroom sink did not look like it has been cleaned, very dirty. Maintenance Supervisor stated dirty sinks were a housekeeping issue. Maintenance Supervisor stated room [ROOM NUMBER]'s bathroom was dirty; a dirty glove was noted on the bathroom floor and there was stool in the toilet bowel. 5. During multiple observations on 02/26/18 from 10:14 a.m. to 3:24 p.m., room [ROOM NUMBER]C's linoleum floor had food particles all around the front of the bed and the overbed table had water spilled all over the top. room [ROOM NUMBER] and 47's bathroom linoleum floor was dirty (dust and ground in dirt) and rust colored stains around the base of the toilet. room [ROOM NUMBER]'s bathroom linoleum floor had multiple brown stains. room [ROOM NUMBER]'s linoleum floor was dirty under the sink and right/left of the sink with dust and small debris. room [ROOM NUMBER]C's linoleum floor was covered with tissue, cotton balls, and food particles. room [ROOM NUMBER]'s bathroom linoleum floor was dirty (multiple of ground in stains). room [ROOM NUMBER]C's linoleum floor had multiple cotton balls near resident's bed and room [ROOM NUMBER]'s bathroom linoleum floor was dirty (splatter/ground in spots) and smelled of urine. room [ROOM NUMBER]'s linoleum floor and resident's bathroom floor was dirty: splatter/ground in spots throughout the linoleum floors. room [ROOM NUMBER]'s bathroom linoleum floor had purplish colored stains under the sink and right side of the sink. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 03/01/18 at 10:50 a.m., Unlicensed Staff N was in room [ROOM NUMBER]C changing the resident's bed linen and helping the resident get cleaned up. Food particles were all over the floor in front of the resident's bed, but Unlicensed Staff N did not clean up the mess or call housekeeping to sweep/mop up the mess. Unlicensed Staff N continued tending to the resident and ignored the mess on the floor as she walked on the mess. When Unlicensed Staff N was done tending to the resident, she left the room and the multitude of food particles remained on the floor. During a housekeeping tour on 3/01/18 at 2:25 p.m.: When Housekeeping Supervisor was asked about the linoleum floor in front of room [ROOM NUMBER]C's bed, Housekeeping Supervisor stated the floor was very dirty, a lot of food spilled. Housekeeping Supervisor stated if housekeeping has already cleaned the resident's floor, nursing needed to call the housekeeper to sweep/remop the floor or nursing staff could have picked up the food the resident spilled. Housekeeping Supervisor stated the sink in room [ROOM NUMBER] was very dirty and needed to be cleaned. Housekeeping Supervisor stated looked like housekeeping did not scrub the sink, which needed to be done. Housekeeping Supervisor stated room [ROOM NUMBER]C's floor was messy; a lot of tissue all over the floor. Housekeeping Supervisor stated if a resident dropped tissue, food particles, etc. or if a nurse/CNA dropped an item such as cotton balls, gloves, etc., the nurse/CNA should pick up the mess in the resident's room/bathroom. Housekeeping Supervisor stated any staff member who went into a resident's room and saw a garbage on the floor should have cleaned up the garbage/mess or call housekeeping if the floor needed to be swept and/or mopped. Housekeeping Supervisor stated the housekeepers cleaned the room daily, but it was the nursing staff who needed to notify the housekeeper if a resident's floor needed to be re-cleaned or if the resident had an accident in the bathroom. Housekeeping Supervisor stated it was every staff member's responsibility to help with cleaning up residents' spills/messy floor. Housekeeping Supervisor stated the residents' rooms and bathrooms were routinely cleaned daily and as needed. Housekeeping Supervisor stated there were three housekeepers for the facility, one housekeeper started at 6 a.m., another housekeeper started at 7 a.m., and the third housekeeper started at 8 a.m. Housekeeping Supervisor stated the facility had been short staffed 2 housekeepers and it had not been until 1 to 3 months ago when two more housekeepers were hired; prior to the two new hirers there had only been one housekeeper and himself cleaning the building. During an interview on 03/02/18 at 02:50 p.m., Housekeeper M stated if a resident's room needed to be cleaned after he had already cleaned the room, a staff member would page him overhead. During a concurrent observation and interview on 3/01/18 at 2:55 p.m., room [ROOM NUMBER]C's floor had food particles all around the front of the bed since 1:00 p.m. Nurses and CNAs were walking on the food particles and then left the room. No staff member cleaned up the mess on the floor. When Licensed Staff A was shown room [ROOM NUMBER]C's messy floor, Licensed Staff A stated when the resident was finished with his/her meal, it was the CNA's responsibility to clean up the floor. Licensed Staff A stated CNAs did not have brooms, but they should call housekeeping and pick up what they can using gloves. Licensed Staff A said, yes, the floor was dirty and should have been cleaned. Licensed Staff A stated it was every staff member's job to help keep residents rooms clean and picked up. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 3/02/18 at 9:10 a.m. room [ROOM NUMBER]'s bathroom sink was still dusty/dirty around the hot/cold handles and a dirty glove was on the floor next to the sink. The facility document titled, Housekeeper/Janitor Job Description, undated, indicated: 1.A housekeepers principle responsibilities was to perform tasks to ensure a safe, comfortable and sanitary environment for all residents, staff and visitors according to established policies and procedures and 2. Maintains written records and documents of services performed according to Federal, State and Corporate requirements. The facility training manual for housekeepers, no title/undated, Module 3 titled, Safety for Healthcare Housekeepers, indicated one of the eight rules of safety was when you see something on the floor that does not belong there, either a spill or an object, mop or pick it up immediately. Module 4 titled, Cleaning the Occupied Patient Unit, indicated the housekeepers were to perform high dusting, clean ledges and seals, spot clean malls, clean furniture, and dust mop floor and wet mop floor. Module 6 titled, Cleaning the Resident Bathroom, indicated the housekeepers were to disinfect the toilet bowl, perform high dusting, clean toilet outer surfaces, clean sink and counter, clean wall splash marks, and dust mop floor and wet mop floor. The facility policy/procedure titled, Housekeeping - Resident Rooms, revised 1/1/12, indicated daily cleaning of residents' room included: 1. overbed table a damp wiped, 2. bathroom is cleaned, sanitized, and disinfected, and 3. floor is swept or vacuumed and then damped mop with disinfectant solution. 6. During an observation on 02/26/18 09:30 AM, Resident 23's electric chair's upholstery was torn at left arm rest and left side of back rest. During an interview on 3/01/18 at 2:30 p.m., when Social Services was asked who would be responsible for maintaining Resident 23's electric chair and repairing the ripped upholstery, Social Services stated maintenance would handle this issue. Social Services stated most of the residences who have an electric chair are veterans, Resident 23 was a private pay. Social Services stated she was aware of the upholstery being torn at the left arm rest and left side of the back rest and would check out what could be done to get the chair repaired. Social Services agreed it would be hard to keep Resident 23's electric chair clean/sanitized because of the torn upholstery. 7. During multiple observations on 02/26/18 from 9:20 a.m. to 10:31 a.m., wheel chair leg rests were stored on room [ROOM NUMBER]A and 56A's unoccupied made up resident bed. Multiple clothing and personal items belonging to the resident in room [ROOM NUMBER]B were stored on room [ROOM NUMBER]A's unoccupied made up resident bed. Multiple personal items were stored on 55A unoccupied resident made up bed. The facility document titled, Certified Nursing Assistant Job Description, undated, indicated CNAs were to make resident's bed, clean bedside and overbed tables. 37160

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. 32961 Based on interview and record review, the facility failed to ensure MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems) staff completed a quarterly MDS assessment timely for one of two sampled residents (Resident 1). This failure resulted in the potential for providing inadequate or inappropriate care for the resident. Findings: Resident 1's annual MDS assessment was dated 9/19/17. The following quarterly MDS was dated 2/19/18, which was five months after the annual MDS. During a concurrent record review and interview on 3/7/18, at 8:17 a.m., Licensed Staff BB stated they did not have a MDS assessment between 9/19/17 and 2/19/18. Licensed Staff BB stated the quarterly MDS assessment was overdue. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.14, dated October 2016, under Quarterly Assessment, indicated the Quarterly assessment must be completed at least every 92 days following the previous assessment.

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Fortuna Rehabilitation and Wellness Center, LP	2321 Newburg Road Fortuna, CA 95540

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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. 32961 Based on interview and record review, the facility failed to ensure MDS staff completed all the MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems) assessments accurately for two of two sampled residents (Resident 1 and 5). This failure resulted in the potential for providing inadequate or inappropriate care for the resident. Findings: 1. Resident 1 Resident 1's MDS assessments date and coding for functional limitation in ROM (range of motion) as following: 2/1/17 quarterly assessment: impaired ROM on one upper and one lower extremities, 4/26/17 quarterly assessment: No impairment on upper and lower extremities, 8/9/17 quarterly assessment: impaired ROM on one upper and one lower extremities, 9/19/17 annual assessment: No impairment on upper and lower extremities, and 2/19/18 quarterly assessment: impaired ROM on two upper and one lower extremities. During a concurrent record review and interview on 3/7/18, at 8:17 a.m., Licensed Staff BB reviewed the above MDS assessments. Licensed Staff BB stated Resident 1 had limited ROM on both hands for a long time. Licensed Staff BB stated the MDS staff should have coded impaired ROM for two upper and one lower extremities for all the above MDS assessments. Licensed Staff BB stated it was coding error from 2/1/17 to 9/19/17. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.14, dated October 2016, indicated to code impairment on both sides if the resident has an upper and/or lower extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury. 35842 2. Resident 5 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/1/18 at 1:40 p.m., when Unlicensed Staff Z was asked about Resident 5's positioning while she was feeding herself in bed, Unlicensed Staff Z stated Resident 5's head was too low, but Resident 5 did have a tendency to lean to the left; almost like her neck is contracted that way. Unlicensed Staff Z stated Resident 5 could not possible reach the plate of pureed food. Unlicensed Staff Z stated the plate of food should have been in front of her and the ice cream and drinks should have been on each side of her plate. Unlicensed Staff Z stated Resident 5 should have been supervised while eating. Unlicensed Staff Z stated a CNA usually went between Resident 5 and Resident 38 to make sure they were feeding themselves properly. Unlicensed Staff Z stated Resident 5 did like to feed herself, but did need supervision/cuing. Unlicensed Staff Z stated again Resident 5 was not positioned correctly; her head of bed should have been elevated in an upright position During an interview on 3/06/18 at 3:37 p.m., Licensed Staff BB was asked why Resident 5's Quarterly MDS for 9/5/17 and Annual MDS for 12/5/17 ADLs (Activities of Daily Living) for eating indicated Resident 5 was a Set-up Help Only when Resident 5's Resident Care Plan - Nutrition -Swallowing, indicated Resident 5's swallowing interventions included staff to monitor Resident 5 for signs and symptoms of aspiration: shortness of breath, wheezing (whistling sound produced in the respiratory airways during breathing), coughing ., instruct resident to swallow after each bite, instruct/cue resident to chin tuck (tip head forward), and elevate head of bed minimum of 90 degrees during meals and for 30 minutes after, etc. Licensed Staff BB stated Resident 5's MDS should have been coded as one person assistant. When asked what she looked at before coding, Licensed Staff BB stated she reviewed the resident's medical records including the physician's History and Physical, Nurse's Progress Notes, and Medication Administration Record, talked to staff and to the resident if they were able to communicate.

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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** 37160 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans for three out of seventeen residents (Resident 16, Resident 1, Resident 48, Resident 5) when: 1) Resident 16 did not receive pain management and palliative (specialized medical and nursing care that focuses on providing relief from the symptoms of pain, physical stress, and mental stress of a terminal diagnosis for people with life-limiting illnesses) care plans that meet her needs. This resulted to Resident 16 suffering from pain. (Cross Reference F 697). 2) Resident 1 did not receive resident-centered care for her hand contractures. This resulted to Resident 1's discomfort and had the potential for skin breakdown and decrease hand range of motion. 3) Resident 48's care plan did not include use of bed alarm and supervision. This resulted to Resident 48 falling. 4) Resident 5 did not have a care plan for Seizures (episode of abnormal electrical activity in the brain causing a person to have uncontrollable shaking that is rapid and rhythmic, with the muscles contract and relax repeatedly). This had the potential for Resident 5 not receiving proper seizure interventions, which could compromise her medical condition. Findings: 1. During the initial sample selection interview on 2/26/18, at 4:34 p.m., Resident 16 stated her morphine pain medicine was cut in half and it would take a while for it to build up in her system. During an interview on 3/05/18, at 4:36 p.m., Hospice Staff P stated, on 2/15/18, the Hospice Service started Resident 16 on low dose Methadone (synthetic, narcotic analgesic (pain reliever) and used for other medical purposes such as pain relief.) and changed the morphine from every two hours to every four hours. Hospice Staff P stated the facility requested to change the morphine because Resident 16 was falling from oversedation (the calming of mental excitement or abatement of physiological function, especially by the administration of a drug). Hospice Staff P stated hospice nurse visits Resident 16 once a week, unless Resident 16 needed more. Hospice Staff P stated the facility staff should contact Hospice Service if Resident 16 reported increasing severity of pain. During an interview on 3/06/18, at 8:26 a.m., Resident 16 stated her pain goal was to get pain level down to 5, where she did not feel like screaming all the time. When asked how often staff were addressing her pain, Resident 16 stated, Nothing really gets done about it. One or two nurses seems to understand and care and the rest ignore you. You can't do anything just lay in there. I haven't been ok for a long time, I tried to act like I'm ok. I tried to smile. When asked how often she have to ask for pain medicine, Resident 16 stated, I don't think if I had it. I feel stupid if I asked and then they told you, 'you had one'. (It) doesn't really help if I had one or not. When asked if the pain medicine helps, Resident 16 stated, It doesn't seem to, I can't tell if had it or not, so obviously it does not help me much (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review on 3/06/18, at 4:53 p.m., when asked how and when do staff try to identify circumstances in which pain can be anticipated for Resident 16, the DON stated Resident 16 started with certain amount of morphine and methadone and that they (Hospice Service) increased methadone to work long term better. The DON stated, She's (Resident 16) pretty good at telling us her pain. The DON stated the Hospice Service increased her long term (long-acting medication) so she doesn't get snowed. The DON stated the facility put Resident 16 on Hospice Service because she likes getting extra attention as told by Resident 16 to the DON. When asked how often Resident 16's pain evaluation was, the DON stated the staff should assess Resident 16 pain at the beginning of every shift, before medication, and report from other shift whether she had pain medication before. The DON stated the staff would call hospice service if Resident 16's pain appeared to be out of control, and the hospice staff could do another reassessment. When asked how staff communicates with the physician about the resident's pain status, current measures to manage pain, and the possible need to modify the current pain management interventions, the DON stated, Hospice is driving her care. When asked how the facility developed the interventions, the DON stated, the facility tried to convince her to get out of her room, to join activity, to put hot pack on shoulders, to rest, and for Resident 16 to lay on her back when sitting in wheelchair for too long. The DON stated, the facility performed conference care between Hospice Service and DON and worked conjunctively (working together). When asked if any of Resident 16's interventions been effective, the DON stated, I think so, I don't think if she would agree with me. The DON stated Resident 16 had high tolerance of pain, that's why it's a work on progress. The DON stated, Her (Resident 16) favorite is every 1 hour pain med, even if you tell her, she forgets. The DON stated the facility have not tried communication board or visual reminders informing Resident 16 about her pain medicine. The DON verified Resident 16 Care Plan for Pain had no measureable goals, no measureable pain assessment frequency, and not Resident 16-centered. During a review of the clinical record for Resident 16, the Palliative Care Form signed and dated by a physician on 11/14/16, indicated, The resident will require the frequent use of narcotic/anti-anxiety/hypnotic medications. The facility/agency will plan and implement measures to maintain the appropriate levels of medication for the resident to ensure comfort. During a review of the clinical record for Resident 16, the Resident Care Plan: Palliative dated 12/17, indicated a problem/need of use of narcotic/anti-anxiety/hypnotic medications with only one planned goal of Resident will be comfortable and pain free through terminal illness. During a review of the clinical record for Resident 16, the Resident Care Plan: Pain dated 12/17, indicated planned goals of Resident will verbalize/show decreased signs and symptoms of pain, and resident will require less pain medication to alleviate pain. The facility did not mark a pre-written planned goals indicating, Resident will achieve self-reported pain goal of (1-10):___; There was no established pain goal for Resident 16. The planned approach indicated, Evaluate need for routine pan medication rather than PRN [as needed]. There care plan did not address oversedation. During a review of the clinical record for Resident 16, the Resident Care Plan: Activities dated 12/17, indicated a problem/need: Due to low endurance and pain, resident cannot tolerate timeout of bed for group activities, Resident is accepting and responsive to 1:1 visits from staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy and procedure titled Comprehensive Person-Centered Care Planning dated 11/17, indicated, The baseline care plan must reflect the resident's stated goals and objectives, and include interventions that address his or her needs. 32961 2. During a concurrent observation and interview on 2/26/18, at 9:22 a.m., Resident 1 was in bed and awake. Resident 1' right hand fingers were in bent positions with the finger tips touching the palm. Resident 1's fourth and fifth of left hand fingers were in bent position with the finger tips touching the palm. Resident 1 used her left thumb and pointing finger and attempted to straighten her right hand fingers. Resident 1 did not have a hand roll (an object that prevent deformities and contractures by placing a hand roll in the patient ' s hand to position and maintain the wrist and fingers in a functional position) or device on hands. Resident 1 stated sometimes staff put a wash cloth to her hand. During a review of Resident 1's care plans on 3/1/18, at 4:35 p.m., Resident 1's fall risk care plan dated 1/30/18, indicated Resident 1 was at risk for fall related to problems including contracture (Hand deformity that causes the tissue under the surface of the hand to thicken and contract, cause fingers into bent position) of right hand. The care plan did not address interventions for the contracture. During a concurrent observation and interview on 3/1/18, at 4:46 p.m., Resident 1 was in bed and awake. Resident 1 did not have any device or hand roll on hands. Resident 1 stated she liked to have something like a small wash cloth roll on hand (holding the roll between fingers and palm) which would make her feel better/comfortable. Resident 1 stated they did not provide something for her right hand on these days, but did not remember for how long. During an interview on 3/1/18, at 4:58 p.m., Unlicensed Staff K stated she was instructed to apply hand roll with a Velcro wrap over Resident 1's hand, but 10/10 times Resident 1 took it out and threw it on the floor. She stated Resident 1 did not want the hand roll. Unlicensed Staff K stated she explained to Resident 1 of the benefits, but Resident 1 still took it off. Unlicensed Staff K stated she notified the charge nurse and no longer applied the hand roll. Unlicensed Staff K stated she was not instructed to apply different hand roll to Resident 1's hands. During a concurrent record review and interview on 3/1/18, at 5:29 p.m., Licensed Staff J stated he did not know a lot of Resident 1's right hand contracture. Licensed Staff J reviewed the MAR (medication administration record) and noticed an order for applying hand roll, which was scheduled FYI (for your information) with no staff signature for completion. Licensed Staff J stated he could not tell if the nurse applied the hand roll or the resident refused it. Resident 1's care plan for activities of daily living (ADL- eating, grooming, toileting) dated 1/30/18, indicated Resident 1 was at risk for declining self-performance of ADL related to multiple problems including left hand contracture. The care plan did not address interventions for the contracture. The Restorative Nursing Program Referral/Care Plans, dated 12/20/17 and 2/1/18, indicated Resident 1 was on restorative nursing program for PROM (passive range of motion) three times per week. The care plan did not address hand roll or device for the contractures. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1's medical chart did not contain a comprehensive person-centered care plan for her right and left hand contractures. Resident 1's MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated from 2/1/17 to 2/19/18, indicated Resident 1 had impaired ROM (range of motion) to one or two upper and lower extremities. During a concurrent record review and interview on 3/6/18, at 10:15 a.m., Licensed Staff H stated Resident 1 had contracture on right and left hands for a few years after Resident 1 had a seizure. Licensed Staff H stated OT (occupational therapy) evaluated and RNA (restorative nursing assistant) worked with Resident 1 for PROM (passive range of motion) three times a day. Licensed Staff H stated they tried to apply brace and wash cloth, but Resident 1 refused the brace and wash cloth. Licensed Staff H stated Resident 1 refused a lot of care and medications, just wanted the television. Licensed Staff H reviewed all care plans and stated the care plans did not address hand brace or roll for contracture. Licensed Staff H reviewed the MAR, which had an order Nursing to assist with application of right hand roll, to be worn at all times .). Licensed Staff H stated the order was scheduled as FYI, so they did not have documentation for offering or refusing. Licensed Staff H stated they did not have documentation of assessing for different device for the hand contracture. During a review of Resident 1's nurses' notes on 3/6/18, at 10:29 a.m., revealed the nurses' notes, dated from 1/20/17 to current last dated 11/14/17 in the chart, did not address hand brace/sprint/roll. During concurrent record reviews and interviews on 3/6/18, at 4:48 p.m. and 5:28 p.m., the Director of Nursing (DON) reviewed all care plans including skin care plan copied on 3/1/18 and acknowledged that the care plans did not address approaches for the hand contracture or Resident 1's refusal of the hand roll. The DON also acknowledged that they did not have a care plan to address how to re-approach or provide alternate hand roll. During a concurrent record review and interview on 3/7/18, at 8:17 a.m., the Licensed Staff BB reviewed the MDS assessments dated from 2/1/17 to 2/19/18. Licensed Staff BB stated Resident 1 had limited ROM for both hands for a long time and should be coded impaired ROM for two upper and one lower extremities for all the above MDS assessments. Licensed Staff BB stated the facility should have developed a person-centered care plan for the hand contractures. Resident 1's physician's order dated 12/14/17, indicated Nursing to assist with application of right hand roll, to be worn at all times to tolerance . Resident 1's MAR (medication administration record) dated February 2018 and March 2018, indicated an order Nursing to assist with application of right hand roll, to be worn at all times to tolerance ., which was scheduled as FYI (for your information). The MARs did not have staff initial or signature for completion or refusal. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an interview on 3/7/18 at 8:30 a.m., Licensed Staff B (who worked the night shift on 3/6/18) stated Resident 48 had tried to get up on his own and was found lying on floor by the CNA making rounds near the change of shift (AM of 3/7/17). Licensed Staff B stated the bed alarm did not go off because the battery was dead. Licensed Staff B stated Resident 48 had no injury. When Licensed Staff B was asked if there was enough nursing staff scheduled for 3/6/18 night shift, she stated a CNA had called in sick on night shift and she was assigned to 38 residents. Licensed Staff B stated there were 2 nurses and 3 CNAs scheduled last night for 68 residents. A review of Resident 48's Quarterly MDS, dated [DATE], indicated Resident 48 had a BIM (Brief Interview for Mental Status- a test given that helps determine a patient's cognitive understanding) score of 3 (severely cognitively impaired), needed one person physical assist with transfer between bed, chair, and wheel chair, one person physical assist with walking, used a walker, and had one fall with a minor injury. During a concurrent record review and interview on 3/7/18, at 9:05 a.m., Licensed Staff H stated Resident 48 had a bed alarm (a device attached to the bed that triggers an alarm when the resident attempts to get up from the bed). Licensed Staff H stated nursing staff should check the battery at least daily and check the bed alarm functioning at least every shift. Licensed Staff H stated this should be in the care plan and in the physician order, but they lacked documentation. Licensed Staff H reviewed the MAR (medication administration record) and stated it was not documented in the MAR. Resident 48's care plan for fall risk prevention and management, initiated on 1/10/18, indicated Resident 48 was at risk for fall due to multiple problems including history of falls, poor balance, lack of awareness, hearing deficit, vision deficit, and cognitive deficit. One of the approaches was to encourage Resident 48 to use assistive device, bed alarm. The care plan was revised to include Replace Battery as needed on 3/7/18 (Resident 48 fell on [DATE] at 1:15 a.m.). The care plan did not specify when and how staff would check the battery or bed alarm functioning. 35842 4. During an interview on 3/8/18 at 12:00 p.m., DON was asked if Resident 5, who had a diagnosis of seizures had a care plan for seizures. DON stated Resident 5 should have been care planned for seizures. DON looked to see if Resident 5 had a care plan for seizures, but DON could not find one. Review of the facility policy/procedure titled, Seizure, revised 4/1/12, indicated: 1. During admission, residents will be evaluated for the potential for seizure activity and findings will be documented in the resident's Care Plan, and 2. Update the resident's Care Plan as necessary.

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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. 32961 Based on observation, interview, and record review, the facility failed to ensure licensed nurses clarified a physician order for blood sugar parameter (blood sugar levels for holding the insulin or call the physician for instructions) for Novolog 70/30 insulin (an insulin mixed with 30 percent short-acting and 70 percent long-acting, a medication for blood sugar control) administration for one unsampled resident (Resident 60). This failure resulted in the potential for abnormally high or low blood sugar, or death to the resident. Findings: During an observation for medication pass on 2/28/18, at 12:20 p.m., Licensed Staff L administered 25 units of Novolog 70/30 to Resident 60 after blood sugar check. Resident 60's physician order, dated 2/25/18, indicated Novolog 70/30 insulin three times a day before meals after blood sugar check and to give 20 units in the morning, 25 units at noon, and 30 units before diner. The order did not include a blood sugar parameter for insulin administration. Resident 60's medication administration record (MAR) indicated Resident 60 had been receiving Novolog 70/30 insulin since 2/26/18 morning. The MAR did not include a blood sugar parameter. During a concurrent record review and interview on 2/28/18, at 1:25 p.m., Licensed Staff L reviewed the physician order and the MAR and stated the order did not specify a parameter for insulin. Licensed Staff L stated every resident should have a specific protocol or parameter for the insulin. Licensed Staff L stated the order was not clear and should have called the physician for clarification. During a concurrent record review and interview on 3/1/18, at 9:25 a.m., the Director of Nursing (DON) reviewed Resident 60's physician order for Novolog 70/30 insulin dated 2/25/18, which did not indicate a parameter for insulin administration. The DON stated the physician order should include a parameter and the parameter was individualized. The DON stated she did not want the nurse to make that decision. The DON further stated the nurse should have clarified the insulin order with the doctor as soon as they received the order. The facility's policy and procedure titled Diabetic Care, revised 1/1/12, indicated .The Attending Physician will write parameters for notification for blood sugar that is out of control .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842 Base on observation, interview, and record review, the facility failed to provide the necessary care and services to maintain 3 out of 17 sampled residents' (Resident 5, 9, and 38) highest practicable physical well-being when: 1. Resident 5 and Resident 38, both diagnosed with cognitive deficits (confusion, poor motor coordination, loss of short-term or long-term memory, identity confusion .) and required meal assistance and cueing, were not supervised and/or assisted with their meals and 2. Resident 9, who was a one person physical assist with grooming, was not assisted with grooming his beard after meals. These failures had the potential for: 1. Resident 5 and Resident 38 to aspirate (food enters the body's airway or lungs), which in severe instances may result in death, and decreased dietary intake and weight loss further compromising the resident's medical status and 2. Resident 9 having an unclean appearance and further compromising his self-worth. (Cross Reference F 725). Findings 1a. Resident 5: A review of Resident 5's admission record, dated 12/12/16, Skilled Nursing Facility History and Physical, dated 12/21/16, Social History, dated 12/21/16, a History and Physical Examination, dated 12/23/15, and Physician Orders, dated 2/18, indicated Resident 5 had diagnoses including expressive aphasia (inability to comprehend and formulate language because of damage to specific brain regions) and right hemiparesis (weakness to the right side of the body, which may involve the arms, hands, legs, face or a combination) because of CVA (cerebral vascular accident - stroke which occurs when blood flow is interrupted to part of the brain), abnormalities with walking and mobility, muscle weakness, convulsions, and dysphagia (difficulty with swallowing). A review of Resident 5's Physician Orders, dated 12/12/16, and Medication Administration Records (MAR), dated 1/18 and 2/18, indicated Resident 5 was on swallowing precautions and needed a straw for thin liquids. Resident 5's annual MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 12/5/17, indicated Resident 5's cognitive skills for daily decision making was severely impaired (never/rarely made decision), the range of motion of upper right extremity (limb) and both lower extremities were impaired, and Resident 5 had a swallowing disorder: loss of liquids/solids from the mouth when eating or swallowing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/06/18 at 3:37 p.m., Licensed Staff BB was asked why Resident 5's Quarterly MDS for 9/5/17 and Annual MDS for 12/5/17 ADLs (Activities of Daily Living) for eating indicated Resident 5 was a Set-up Help Only when Resident 5's Resident Care Plan - Nutrition -Swallowing, indicated Resident 5's swallowing interventions included staff to monitor Resident 5 for signs and symptoms of aspiration: shortness of breath, wheezing (whistling sound produced in the respiratory airways during breathing), coughing ., instruct resident to swallow after each bite, instruct/cue resident to chin tuck (tip head forward), and elevate head of bed minimum of 90 degrees during meals and for 30 minutes after, etc. Licensed Staff BB stated Resident 5's MDS should have been coded as One Person Assistant. When asked what she looked at before coding, Licensed Staff BB stated she reviewed the resident's medical records including the physician's History and Physical, Nurse's Progress Notes, and Medication Administration Record, and talked to nursing staff and to the resident, if they were able to communicate A review of Resident 5's Resident Care Plan - Nutrition-Swallowing Impairment, dated 12/17/18, indicated swallowing interventions included monitor for signs and symptoms of aspiration: shortness of breath, wheezing (whistling sound produced in the respiratory airways during breathing), coughing ., instruct resident to swallow after each bite, instruct/cue resident to chin tuck (tip head forward), and elevate head of bed minimum of 90 degrees during meals and for 30 minutes after. These care plan interventions were not being followed. During an observation on 2/26/18 at 1:15 p.m., Resident 5 was in a light weight hospital gown, which was not tied and caused her upper chest to be fully exposed. Resident 5 was positioned at approximately a 45 degree angle for lunch. Resident 5 was on a puree diet, which was over her bed, but no one was assisting Resident 5 with her meal and food particles were all over her. No straw was in her glass per physician's order. During a concurrent observation and interview on 2/28/18 at 2:10 p.m., Resident 5 was feeding herself a pureed diet. Resident 5's was positioned at a 45-degree angle while eating, napkin was not in place and food was all over Resident 5's clothes and blankets. There was no staff supervising Resident 5 while she was eating her meal. Resident 5's breathing sounded a little raspy after meal. Licensed Staff H stated Resident 5 did need assistance. Licensed Staff H stated Resident 5 did have a bib, but she had pulled it off and it was under her covers. Licensed Staff H stated the certified nursing assistant (CNA) would go between Resident 5 and Resident 38, but there was not enough staff to assist residents who were eating in their room and in the assisted dining room at the same time. Licensed Staff H stated the CNAs assisted the residents in the assisted dining room first and then the residents who wanted to eat in their room. During a concurrent observation and interview on 3/1/18 at 1:40 p.m., when Unlicensed Staff Z was asked about Resident 5's positioning while she was feeding herself in bed, Unlicensed Staff Z stated Resident 5's head was too low, but Resident 5 did have a tendency to lean to the left; almost like her neck is contracted that way. Unlicensed Staff Z stated Resident 5 could not possible reach the plate of pureed food. Unlicensed Staff Z stated the plate of food should have been in front of her and the ice cream and drinks should have been on each side of her plate. Unlicensed Staff Z stated Resident 5 should have been supervised while eating. Unlicensed Staff Z stated a CNA usually went between Resident 5 and Resident 38 to make sure they were feeding themselves properly. Unlicensed Staff Z stated Resident 5 did like to feed herself, but did need supervision/cuing. Unlicensed Staff Z stated again Resident 5 was not positioned correctly; her head of bed should have been elevated in an upright position (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/02/18 at 9:00 a.m., a suction machine was located at near Resident 5's bed, positioned against the wall near the head of her bed. When Staff Coordinator was asked why Resident 5 had a suction machine, Staff Coordinator stated Resident 5 was on aspiration precautions. During an interview on 3/6/18 at 9:58 a.m., DON stated Resident 5 had a major stroke and the suction machine was by her bedside just for aspiration precautions. During an interview on 3/6/18 at 10:59 a.m., Occupational Therapist (OT) stated Resident 5 had refused to be assisted with her meals, but should have been supervised for cuing and aspiration precautions plus needed to be set-up in a way to reach her plate and fluids. OT stated Resident 5 did need to be spot checked and intermittent cuing; this was why I just placed her on 1:1 supervision with meals. OT stated the meal tray needed to be within range for Resident 5 to reach food and help prevent food from falling all over her. 1b. Resident 38 A review of Resident 38's admission record, dated 1/10/18 Hospice Clinical Notes, dated 1/12/18, and Dietary/ Nutritional Assessment, dated 1/10/18, indicated Resident 38 had diagnoses including Alzheimer's (most common cause of dementia, a group of brain disorders that results in the loss of intellectual and social skills. These changes are severe enough to interfere with day-to-day life), peripheral vascular disease (a blood circulation disorder that causes the blood vessels outside of your heart and brain to narrow, block, or spasm), breast cancer, and seizures (episodes of uncontrolled electrical activity in the brain, which could produce a physical convulsion (a sudden, violent irregular movement of a limb of the body). A review of Resident 38's Interdisciplinary Team Conference Record, dated 1/11/17, indicated Resident 38 was: 1. admitted to the facility on hospice (end of life care) and 2. required total assist with activities of daily living (ADLs - eating, bathing, dressing, transferring .). Resident 38's Admission MDS, dated [DATE], indicated Resident 38's cognitive skills for daily decision making was severely impaired (never/rarely made decision), and Resident 38 had a swallowing disorder: loss of liquids/solids from the mouth when eating or swallowing. A review of Resident 38's Resident Care Plan - Activities of Daily Living, dated 1/11/18 and Resident Care Plan - Nutrition and Hydration, dated 1/15/18, indicated Resident 38 needed assistance with eating and bed mobility, decreased food intake, history of weight loss, dysphagia, cognitive impairment, and decreased feeding skills. Interventions for Resident 38 included total meal assist, encourage sipping cup, offer fluids frequently, and encourage oral fluids and eating at each meal. Total meal assist was not occurring. During an observation on 2/26/18 at 1:19 p.m. Resident 38 was eating her pureed lunch unassisted in bed. Resident 38 was positioned at a 45 degree angle and leaning to the right side. Resident 38's overbed table was positioned to the side of the bed, so Resident 38 could not reach her tray. Resident 38's plate of pureed beans and taco casserole was uncovered and no one came to assist her. Resident 38 was holding a bowl of pureed food and was scooping the food out with her hand. Resident 38 was still in her hospital gown and there was food all over her chest. Resident 38 did have a sipping cup, but she also had a non-adaptive glass filled to the top and out of reach. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/28/18 at 1:55 p.m., Resident 38 was having her lunch in bed unassisted. Resident 38 was holding her sipping cup and trying to drink from it, but she was having difficulty bring the cup to her mouth. Resident 38 had no napkin on her and milk was dripping all over her. Resident 38's pureed lunch tray was on her overbed table, but Resident 38 had slid down in the bed and could not reach her lunch tray. During a concurrent observation and interview on 2/28/18 at 2:00 p.m., Licensed Staff H was asked to see Resident 38's position in bed as Resident 38 attempted to feed herself lunch. Licensed Staff H stated Resident 38 was not positioned correctly in bed for lunch in order for Resident 38 to reach her meal tray. Licensed Staff H stated Resident 38 was down to low in the bed. Licensed Staff H stated Resident 38's daughter had requested Resident 38 attempt to feed herself first. Licensed Staff H stated Resident 38 did use her fingers to feed herself and Resident 38's daughter was aware. Licensed Staff H stated Resident 38 should have been assisted with her lunch, but the CNA had to assist the residences in the assisted dining room first and then assist the residences eating in their room. Resident 38 was trying to feed her stuffed monkey the sipping cup full of milk. During an interview on 2/28/28 at 5:45 p.m., when Unlicensed Staff AA was asked how she goes about supervising Resident 38 for her meals, Unlicensed Staff AA stated she would first pass out the trays to the residents wanting to eat in their room and then to the residents in the assisted dining room. Unlicensed Staff AA stated she would first assist Resident 38 with her meal then go down to the assisted dining room to help out. Unlicensed Staff AA stated she assisted Resident 38 with her dinner because she needed assistance with her meals. Unlicensed Staff AA stated Resident 38 would forget how to hold her sipping cup and it would start to drip. Unlicensed Staff AA stated Resident 38 needed assistance with her pureed food as well. During an interview on 3/7/18 at 8:45 a.m., Confidential X stated the facility knew Resident 38 was total care and needed assistance with eating. Confidential X stated she/he never said it was okay for Resident 38 to use her fingers to scoop out food from a bowl. Confidential X was very upset and sounded very sad because she/he did not live near the facility and was relying on the staff to take good care of Resident 38. Confidential X stated Resident 38 was a total assist. Confidential X stated Resident 38 had severe dementia, so one did not know from one minute to the next if Resident 38 could feed herself or needed to be assisted. Confidential X stated someone really needed to supervise Resident 38 with her meals. Confidential X stated Resident 38 needed total assistance with hygiene, positioning, meals Confidential X stated Resident 38 could not even turn herself. During an interview on 3/7/18 at 9:15 a.m., DON stated Resident 38 should have been positioned upright for her meals, but Resident 38's daughter wanted her to be independent with her meals as much as possible. DON stated it would be better if Resident 38 could have finger foods, but she was on a pureed diet. DON was asked if she thought there was a dignity/safety issue regarding Resident 38 using her fingers to scoop pureed food out of a bowl. DON stated the CNA did make rounds to see if Resident 38 was okay with feeding herself. DON did not see a dignity issue with Resident 38 scooping food out of a bowl with her fingers. DON did not see a safety issue with Resident 38 eating her meals unassisted even after it was brought to her attention Resident 38 had been trying to eat her lunch unassisted on 2/26/18 while positioned at a 45 degree angle, Resident 38's plate had been uncovered, but her overbed table was out of reach, no CNA was in the hallway because the CNAs were in the assisted dining room assisting residents, and Resident 38 was care planned for needing Total Meal Assist. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy/procedure titled, Feeding the Resident, revised 1/1/12, indicated: 1. Residents are positioned in an upright position to prevent choking or aspiration, 2. Clothing protectors are provided to assist with keeping clothes free from spills, 3. Trays are arranged to assist residents to feed themselves if possible, 4. Residents incapable of feeding themselves are fed by Nursing Staff, 5. Do not serve the meal until you are ready to feed the resident, 6. Wash the resident's hands and face after removing the meal tray . The facility policy/procedure titled, Certified Nursing Assistant - Job Description, undated, indicated CNAs duties included: 1. Assist in preparing residents meals (placing bibs, assisting in feeding, etc.), 2. Feed residents who cannot feed themselves, 3. Assure that resident's food is accessible and self-help devises are available as needed, 4. Place residents in correct and comfortable position, and 5. Perform after meal care are required - cleaning resident's hands, face, clothing, dentures, etc. 37160 2. During an observation on 3/01/18, at 2:13 p.m., in the nurse station, Resident 9 had food stain on his chin with grown facial hair. During an observation on 3/01/18, at 2:31 p.m., Licensed Staff E gave Resident 9 a drink and stated another CNA (Certified Nursing Assistant) was getting a washcloth to clean his face. At 2:33 p.m., Licensed Staff E assisted Resident 9 to his room. During an observation on 3/05/18, at 1:05 p.m., in the nurse station, Resident 9 had food stain around his shaven mouth. During an interview on 3/06/18, at 9:38 a.m., Staff Coordinator stated assisting Resident 9 with ADL (activities of daily living) included toileting, changing clothes, grooming, providing oral care, dressing, assisting with eating, making sure his face is clean after eating, and shaving. Staff Coordinator stated shaving was supposed to be every day, at least twice a week during shower. During a review of the clinical record for Resident 9, the Minimum Data Set (resident assessment stool) indicated Resident 9 needed extensive assistance (resident involved in activity, staff provide weight bearing support) with eating and hygiene. The facility policy and procedure titled Grooming dated 1/1/12, indicated, The facility will work with residents to improve their ability to groom him/herself to promote independence, hygiene, comfort, self-esteem and dignity by teaching the resident to groom him/herself with the use of assistive devices or techniques and with the appropriate types of amount of assistance.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38088 Based on observation, interview and record review, the facility failed to ensure there was a comprehensive plan of care for contracture and range of motion (ROM) for 1 of 15 residents (Unsampled Resident 67). The failure to develop a contracture / range of motion care plan did not ensure the implementation of contracture / ROM interventions, evaluation of contracture treatment, goals of the treatment and revision of the treatment plan if needed. This had the potential to decrease the Resident's ROM, limited independence, and did not ensure the Resident was achieving his highest practicable level of functioning. Findings: During an observation on 5/2/18, at 11:15 a.m., Resident 67 was observed to have a right arm/hand contracture which caused his arm to be flexed up to his shoulder and his right hand to be bent at the wrist at a 90 degree angle. No positioning device was observed in his right hand. During an observation on 5/3/18, at 2 p.m., Resident 67 was observed to have a fleece protector attached to palm of his right hand. During an interview on 5/3/18, at 2:10 p.m., Nurse D was unable to state the contracture plan of care for Resident 67 without prompting. During an interview on 5/3/18, at 3 p.m., Certified Nursing Assistant / Rehabilitation Nursing Assistant (CNA / RNA) C stated a resident in the Rehabilitation Nursing Assistant (RNA) Program is usually who is a long term resident needing range of motion (ROM) and is specific to that resident. CNA / RNA C stated a resident with contracture of the upper extremities would receive ROM for contractures including exercises and braces. She stated Resident 67 was not in the RNA program. During an interview and concurrent record review on 5/3/18, at 2:10 p.m., the Charge Nurse was asked to state what the plan of care was for Resident 67. She did not mention ROM / contracture. When asked about Resident 67's contracture of his right arm / hand, she stated well if has a contracture he might be in the RNA program. She stated she was in charge of the RNA program and didn't remember him being on the list. A review of the list indicated Resident 67 was not on the list. A review of the care plans for Resident 67 indicated he did not have a care plan for ROM or contracture. The Charge nurse stated I don't see anything about contracture / ROM in his chart. A review of a document titled Resident Care Plan Skin indicated on 3/18 an approach described as Nurse to apply hand roll for Right hand. May remove for hygiene purposes. There was no ROM or mention of a palm protector. A review of the document titled Medication Administration Record dated May 2018 indicated Nursing to apply hand roll Right Hand at all times, may remove for hygiene purposes order date 7/1/17. The documentation indicated initials for AM, PM and Night shift per day from 5/1/18 - 5/3/18. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 5/3/18, at 2:10 p.m., the Charge nurse reviewed the Physician's orders for Resident 67 and stated a palm protector device was ordered 5/1/18 and acknowledged by physical therapy. She stated there is an expectation that if a doctor orders anything for ROM / contracture it needed to be addressed in the care plan in 24 hours. She stated she did not receive any communications from anyone regarding Resident 67's contracture. During an interview and record review on 5/3/18, at 2:30 p.m., the Medical Data Set (MDS-A process that provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.), Nurse stated in the Inter Departmental Team (IDT) meeting, the plan of care, MDS and functional status was reviewed. She also stated we would have immediately addressed ROM / Contracture for a resident by placing them on the RNA program list, possibly splint or palm protector and update the care plan. During an interview on 5/3/18, at 3:30 p.m., the MDS Nurse. Director of Rehabilitation and Administrator were asked to provide evidence of a plan of care for Resident 67's ROM / contracture of his right hand. They reviewed the Resident's chart and were unable to find a care plan for contracture / ROM. During an interview on 5/3/18, at 3:20 p.m., The Director of Rehabilitation stated she evaluated Resident 67 on 5/1/18. She ordered a palm protector, put one on him and told the nurses to document in the care plan. She stated she expected to see documentation of ROM and the palm protector beginning 5/1/18. A review of the facility Policy and Procedure titled Comprehensive Person-Centered Care Planning dated November 2017 indicated IV. Comprehensive Care Plan b. Additional changes or updates to the resident's care plan will be made based on the assessed needs of the resident. C. The comprehensive care plan will be periodically reviewed and revised by IDT after each assessment which means after each MDS assessment as required, .iv. To address changes in behavior and care; A review of a document titled Interdisciplinary Team Conference Record dated 12/16/16 for Resident 67 on admission, did not indicate documentation of a contracture / ROM. A review of a document titled Interdisciplinary Team Conference Record dated 3/9/18 for Resident 15 for Quarterly Review indicated a discussion occurred that included care plans and physical function, but comments did not include any language about ROM / contracture. A review of Documents titled Resident Care Plan for Resident 67 did not produce a care plan for ROM / contracture. A review of the document from the MDS titled Section G Functional Status indicated under G0400 Functional Limitation in Range of Motion, Resident 67 was coded for Impairment on one side (Upper Extremity (Shoulder, elbow, wrist, hand). A review of the document titled Visit Diagnoses for a Nursing Home Visit by the Provider for Resident 67, dated 11/13/17 and 3/22/18 indicated Flexion contracture of joint of hand, right.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32961 35842 Based on interview and record review, the facility failed to ensure resident's safety when nursing staff did not evaluate, develop, and implement adequate interventions and did not implement adequate supervision and assistance for 3 Unsampled Residents (Resident 45 48, and 63), who had poor safety awareness and a history of falls, to prevent multiple falls. This failure contributed to: 1. Resident 45 fell 2 times in a 5-month period from 6/27/17 to 11/24/17. 2. Resident 63 fell 3 times in a 4-month period from 9/18/17 to 1/25/18. The fall on 11/10/17 resulted in right forehead swelling and the fall on 1/25/18 resulted in a left hip fracture, which required admission to an acute care facility for treatment. 3. Resident 48 fell while trying to get up on his own on 3/7/18. Resident 48's bed alarm battery was dead at the time of fall. Findings: 1. A review of Resident 45's admission record, dated 2/28/11, and readmit, dated 2/24/16, Resident 45's physician Progress Note, dated 6/14/17 and 1/18/18, and History and Physical, dated 7/19/17, revealed Resident 24 had diagnoses including dementia (memory loss that gets worse over time), difficulty in walking, muscle weakness [worse in upper extremities due to cerebral vascular accident (Stroke caused by a disruption of the blood supply to a part of the brain)], lack of coordination, history of falling, dysphagia (difficulty with swallowing), and aphagia (inability or refusal to swallow). Resident 45's quarterly MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 5/10/17, indicated Resident 45's BIM (Brief Interview of Mental Status) of 7 (a score of 7 or less represented severely cognitively impaired), walking did not occur, and one person physical assist with moving from a seated to standing position, moving on and off the toilet, and transfer between bed and chair or wheelchair. Resident 45's Fall Risk Assessment, dated 5/9/17, indicated Resident 45 had a score of 17 (a score of ten or greater represented high fall risk). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 45's Resident Care Plan for Fall Risk Prevention and Management, dated 2/9/17, indicated fall risk interventions included orient resident to the environment each time changes are made, call light within reach and remind resident to use call light, bed in a low position, and encourage use of wheelchair and transfer pole [A transfer device (floor-to-ceiling grab bar) used to promote independent standing and transferring for residents with weakened strength]. Resident 45's Fall Risk care plan did not specify: 1. how the facility would provide reminders so Resident 45 would remember to ask for assistance with transferring, 2. how often the facility would do visual checks/supervision, and 3. the need for assistance when transferring to the wheelchair or when using the transfer pole. A review of Resident 45's Physician Recap Orders, dated 3/18, indicated Resident 45 was to have nursing assist with safety functional mobility with standing balance at transfer pole. Order originated on 3/28/16. First Fall A review of Resident 45's SBAR (Subject, Situation, Assessment, Recommendation) Communication Form, dated 6/27/17, Licensed Nurses Notes, dated 6/28/17 and Interdisciplinary Team (a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the resident) Conference Record, dated 6/28/17, indicated Resident 45 had a unwitnessed fall on the AM shift on 6/27/17. Resident 45 was found on the floor next to his bed. Resident 45 told staff he had tried to transfer from the wheelchair to the bed on his own and ended up falling on his bottom because his wheelchair had moved from under him. Fall 2 A review of Resident 45's SBAR Communication Form, dated 11/24/17, Post Fall Assessment, dated 11/24/17, and Interdisciplinary Team (IDT) Conference Record, dated 11/27/17, indicated Resident 48 had an unwitnessed fall on 11/24/17 in the dining room. Resident 48 told staff he slipped out of his wheelchair while attempting to propel himself back to his room without assistance. Resident 45 had slight redness to back of head. A review of Resident 45's Resident Care Alert, dated 6/28/17 and Certified Nursing Assist (CNA) Instructions for Bed Mobility and Transfers, dated 6/21/17, indicated: 1. Resident 45 was not to be left in a room while in his wheelchair unattended, 2. Resident 45 was to be assisted from his wheelchair to his bed to avoid self-transfers, and 3. Resident 45 needed two person assist using a gait belt (An assistive devices used to help lift, position and secure individuals during walking and transfers) when transferring from the bed to the wheelchair while using a transfer pole. Resident 45's Fall Risk Assessment, dated 10/21/17, indicated Resident 45 had a score of 12 (a score of ten or greater represented high fall risk. Resident 45's quarterly MDS, dated [DATE], indicated Resident 45's BIM of 5 (severely cognitively impaired), needed one person physical assist with transfer between bed and wheel chair, and had one fall with no injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 45's Resident Care Plan for Fall Risk Prevention and Management, revised 10/21/17, did not indicated any new fall risk interventions. The care plan for falls did not specify how the facility would provide supervision to prevent Resident 45 from falling, who was severely cognitively impaired, and continued to be left unattended in a wheelchair. A review of Physical Therapy Progress Report, dated 11/6/17, indicated Resident 45 had decreased balance, body awareness deficits, gross motor coordination deficits (skills which are important for major body movement such as walking, maintaining balance, coordination, and jumping), and strength impairments. During an interview on 3/1/18 at 10:50 a.m., when Unlicensed Staff N was asked about Resident 45's mobility, Unlicensed Staff N stated Resident 45 should not get up on his own. Unlicensed Staff N stated Resident 45 did have a transfer pole, but Resident 45 should not have a transfer pole because he tries to self-transfer himself and he is not able to. Unlicensed Staff N stated Resident 45 needed two people to assist with his shower. Unlicensed Staff N stated Resident 45 could walk approximately 20 feet (from the nurse's station (North Lytle) to his room, but needed to be assisted. When Unlicensed Staff N was asked how she was made aware of Resident 45's need for assistance with transferring, Unlicensed Staff N stated she was made aware by the CNA tending to Resident 45 from the previous shift. Unlicensed Staff N stated Resident 45 had a physical therapy evaluation and had transfer instructions located on the wall near his bed. 2. A review of Resident 63's admission record, dated 9/13/17 and readmitted d, 1/31/18, Physician Orders, dated 12/17, and an Emergency Department Report, dated 9/13/17, indicated Resident 63's diagnosis included Alzheimer's disease (most common cause of dementia, a group of brain disorders that results in the loss of intellectual and social skills. These changes are severe enough to interfere with day-to-day life), muscle weakness, difficulty in walking, muscle weakness, and dysphagia. A review of Resident 63's Admission MDS, dated [DATE], indicated Resident 63 had a BIM score of 1 (severely cognitively impaired), needed two plus person physical assist with transfer, did not walk, one person physical assist while in wheelchair, and Resident 63 had an unsteady balance during transitions from seated to stand position and transfer between bed and chair or wheelchair. Resident 63's Fall Risk Assessment, dated 9/19/17, indicated Resident 62 had a score of 15 (a score of ten or greater represented high fall risk). A review of Resident 63's Resident Care Plan for Fall Risk Prevention and Management, dated 9/15/17, indicated Resident 63 had limited mobility, poor balance, cognitive deficit (resulting in confusion, poor motor coordination, and loss of short-term or long-term memory), unsteady gait, forgets to call/wait for assistance, impulsive behavior, history of falls, muscle weakness, and difficulty in walking. Fall risk interventions included orient resident to environment each time changes occur, call light within reach, remind resident to use call light, and bed in low position. A review of Resident 63's medical records indicated she had fallen on 9/18/17, 11/10/17, and 1/25/18. During an interview on 3/07/18 at 10:50 a.m., Medical Records was asked to locate SBAR/IDT notes regarding falls due Resident 63's chart was thinned out and none were in her chart. No SBAR was provided for the fall, which occurred on 9/18/17. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/07/18 at 11:05 a.m., surveyor asked Consultant to see Resident 63's investigation reports for falls, which occurred on 9/18/17, 11/10/17, and 1/25/18; none were provided. No SBAR was provided for the fall, which occurred on 9/18/17 and no nurse's notes were provided detailing post fall neuro checks (level of consciousness, movement, sensation .). Fall 1 A review of Resident 63's IDT Conference Record, dated 9/19/18, indicated CNA was giving care to Resident 63's roommate on 9/18/17, when CNA heard Resident 63 call out. Resident 63 was found on the left side of her bed on the floor. The fall caused a small laceration (cut, tear) on Resident 63's left shoulder. The IDT note indicated Resident 63's bed was to be moved up against the wall for safety, and when Resident 63 was in bed a floor mat (helps reduce injuries caused by resident falling out of bed) would be placed on the floor next to the bed. A review of Resident 63's Resident Care Plan Short Term, dated 9/19/17, indicated to move bed against wall and have drop mat on floor when resident is in bed. A review of Resident 63's Resident Care Plan for Fall Risk Prevention and Management, dated 9/15/18, was not updated and did not indicated any new fall risk interventions. Fall 2 A review of Resident 63's SBAR (Subject, Situation, Assessment, Recommendation) Communication Form, dated 11/10/17, Post Fall Assessment, dated 11/10/17, and IDT Conference Record, undated, indicated Resident 63 had an unwitnessed fall on 11/10/17 at about 2:30 p.m. Resident 63 was found on her buttock (behind) next to her bed. Resident 63 sustained right side of forehead swelling from the fall. Resident 63 was unable to recall what she was doing due to her dementia. Resident 63 was not able to be educated about waiting for assistance and using call light due to severe dementia. A review of Resident 63's Resident Care Plan Short Term, dated 11/13//17, indicated to apply first aid to forehead and for Resident 63 to continue to work with physical therapy for safety. A review of Resident 63's Resident Care Plan for Fall Risk Prevention and Management, dated 9/15/18, was not updated and did not indicated any new fall risk interventions. The care plan for falls did not specify how the facility would provide supervision and how often staff should make room rounds for Resident 63, who was severely cognitively impaired. Fall 3 A review of Resident 63's SBAR (Subject, Situation, Assessment, Recommendation) Communication Form, dated 1/25/18, Post Fall Assessment, dated 1/25/18, and IDT Conference Record, undated, indicated Resident 63 had an unwitnessed fall on 1/25/18 at about 4 p.m. Resident 63 was found lying on the floor on her left side wrapped in her blanket. Resident 63 screamed when nurse tried to assess left leg. Resident 63 was sent to an acute care emergency department for an evaluation of the left hip. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 63's Surgery and Procedure Report, dated 1/27/18 and Discharge Summary Report, dated 1/31/18, indicated Resident 63 had sustained a fracture of the left hip and had surgery. Resident 63 had to have 4 units of blood post injury due to Resident 63's hemoglobin (The main functional constituent of the red blood cell, serving as the oxygen-carrying protein); was 6.9 [Normal level was 12-16 g/dL (grams/deciliter)] During an interview on 3/6/18 at 5:15 p.m., surveyor had to ask for SBAR, care plan for falls prior to 1/25/18 fall, Fall Risk Evaluation prior to fall and Post Fall Assessment because they were not in Resident 63's chart. Investigation Report was not provided. Resident 63's chart was thinned. When DON was asked how can contracted/traveling nurses get to know the residents if the residents' charts are thinned, DON stated Resident 63 was considered a new admit because she was transferred to an acute care facility for more than one day. DON stated a resident's chart only had a 3 month window of information. DON stated Resident 63's fall with major injury was not an unusual occurrence for Resident 63, due to her diagnosis of Alzheimer's. During an interview on 3/7/18 at 8:45 a.m., DON (Director of Nursing) stated Resident 63 walked out near her bedroom door and DON heard the fall and went right into Resident 63's room. DON stated Resident 63 was transferred to an acute care facility for further evaluation. DON stated Resident 63 forgets she cannot walk on her own and needed assistance even with transferring from the bed to the wheelchair. DON stated the fall took place on 1/25/18 at around 3 p.m. (change of shift). DON stated Resident 63 had a drop mat and was spot checked frequently (sometimes 20, 40, 60 minute checks). When the DON was asked how a CNA could be pulled to do almost a 1:1 supervision on Resident 63 when the facility did not have enough CNAs to supervise residents who were eating in their rooms and needed to be supervised (per a concurrent observation and interview on 2/28/18 at 2:10 p.m., there was no staff supervising Resident 5 while she was eating her meal. Licensed Staff H stated the certified nursing assistant (CNA) would go between Resident 5 and Resident 38, but there was not enough staff to assist residents who were eating in their room and in the assisted dining room at the same time.); DON could not answer question. DON stated the close monitoring for Resident 63 happened at times. DON stated Resident 63 did not have a bed alarm. DON stated Resident 63 could communicate, but rarely made since. 3. During an interview on 3/7/18 at 8:30 a.m., Licensed Staff B (who worked the night shift on 3/6/18) stated Resident 48 had tried to get up on his own and was found lying on floor by the CNA making rounds near the change of shift (AM of 3/7/17). Licensed Staff B stated the bed alarm did not go off because the battery was dead. Licensed Staff B stated Resident 48 had no injury. When Licensed Staff B was asked if there was enough nursing staff scheduled for 3/6/18 night shift, she stated a CNA had called in sick on the night shift, so they were short one CNA. Licensed Staff B stated she was assigned to 38 residents; there were 2 nurses and 3 CNAs scheduled last night for 68 residents. A review of Resident 48's Quarterly MDS, dated [DATE], indicated Resident 48 had a BIM score of 3 (severely cognitively impaired), needed one person physical assist with transfer between bed, chair, and wheel chair, one person physical assist with walking, used a walker, and had one fall with a minor injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent record review and interview on 3/7/18, at 9:05 a.m., Licensed Staff H stated Resident 48 had a bed alarm (a device attached to the bed that triggers an alarm when the resident attempts to get up from the bed). Licensed Staff H stated nursing staff should check the battery at least daily and check bed alarm functioning at least every shift. Licensed Staff H stated this should be addressed in the care plan and in the physician order, but they lacked documentation. Licensed Staff H reviewed the MAR (medication administration record) and stated no documentation for the bed alarm. She stated it could be documented in the TAR (treatment administration record). Licensed Staff H further stated they should have care instructions in Resident 48's room for CNAs (certified nursing assistant) to check the bed alarm. Licensed Staff H reviewed all the care instructions in Resident 48's room and stated no instruction for the bed alarm. During a concurrent record review and interview on 3/7/18, at 9:09 a.m., Licensed Staff J reviewed the TAR and stated no order or documentation for the bed alarm. Resident 48's physician order list, dated March 2018, did not include an order for the bed alarm. Resident 48's care plan for fall risk prevention and management, dated on 1/10/18, indicated Resident 48 was at risk for fall due to multiple problems including history of falls, poor balance, lack of awareness, hearing deficit, vision deficit, and cognitive deficit. One of the approaches was to encourage Resident 48 to use of assistive device, bed alarm. The care plan was revised to include Replace Battery as needed on 3/7/18 (Resident 48 fell on [DATE] at 1:15 a.m.). The care plan did not specify when and how staff would check the battery or bed alarm functioning. The care plan did not specify providing supervision to Resident 48 to prevent falls. Review of the facility policy/procedure titled, Fall Management Program, revised 11/7/16, indicated: 1. The Licensed Nurse and/or IDT will develop a Plan of Care according to the identified risk factors and root cause per Care Area Assessment guidelines, 2. Following each Fall, the Licensed Nurse will perform a Post-Fall Assessment and update, initiate or revise a Plan of Care, 3. Once the post fall huddle is complete the Licensed Nurse will update the care plan with immediate recommendations, 4. The IDT will summarize conclusions after their review of the fall and circumstances surrounding the fall . The plan of care will also be reviewed and the care plan will be revised as necessary in an effort to prevent further falls with a major injury, and 5. A resident who sustains multiple falls as defined as more than one fall in a day, a week, or month, will be considered a high risk to fall and as a result may sustain a major injury. These residents may be identified by a special logo or designation to alert staff to their high risk activity, may require more frequent observation of activities and whereabouts .

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 37160 Based on observation, interview, and record review, the facility failed to provide pain management to one of seventeen residents (Resident 16) when Resident 16 complaint of pain and she did not received care based on comprehensive person-centered care plan to meet Resident 16's goals and preferences. This failure resulted to Resident 16 experiencing pain and felt like screaming. Findings: During the initial interview on 2/26/18, at 4:34 p.m. Resident 16 stated her morphine pain medicine was cut in half and it would take a while for it to build up in her system. During the record review on 2/26/18, at 4:39 p.m., the medical records indicated Resident 16 had diagnosis of Chronic Pain Syndrome (pain associated with significant psychosocial dysfunction. A pain lasts longer than six months. It is the combination of chronic pain and the secondary complications that are making the original pain worse), stiffness of unspecified shoulder, muscle weakness, and Chronic Obstructive Pulmonary Disease (COPD- is a progressive disease that makes it hard to breath that gets worse over time). The facility put Resident 16 on Hospice service (services provided to a terminally ill individual) on 12/4/17. The Hospice Clinical notes, dated 12/4/17, indicated, .I [Hospice Service Physician] expect she will survive fewer than 6 months. The most recent Minimum Data Set (resident assessment tool) dated 12/11/17, indicated Resident 16 had a moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses.), in which Resident 16 was able to recall 2 out of 3 words without cues. During an observation and interview on 3/01/18, at 10:43 a.m. while sitting on the wheelchair, Resident 16 stated, Pain is bad. I don't know who to ask for it and talk about it. When asked how she calls for assistance, Resident 16 activated her call light. Resident 16 stated, Sometimes it takes one hour for somebody to come in and another hour to get (help with whatever she needs). During an observation on 3/01/18, at 10:46 a.m., Licensed Staff J entered Resident 16's room and answered the call light. Licensed Staff J asked Resident 16 what she needed; Resident 16 said she was in pain. Licensed Staff J asked Resident 16 where the pain was; Resident 16 stated, Everywhere, it's been quite a while, it's been increasing, and then Resident 16 pointed to her mid-lower abdomen. Resident 16 stated, It's been there two months, it hurts when I turn over. Resident 16 stated the abdominal pain was at 10 level (10/10- 10 being the highest pain) when Licensed Staff J asked. Resident 16 stated, Nothing helps, you have to find out what it is. Licensed Staff J asked Resident 16 where her other pain was. Resident 16 stated, Osteoporosis pain, 8 (pain level). Licensed Staff J told Resident 16 he would tell Resident 16's nurse. During an observation on 3/01/18, at 10:54 a.m., Licensed Staff J returned and told Resident 16 the nurse was coming to address Resident 16's pain complaint. During an observation and observation on 3/03/01/18 at 1:48 p.m., Resident 16 was sitting on her wheelchair. When asked about her pain, Resident 16 stated, I have to wait for 4 hours, I didn't know when the last time I got it or when can I get it (pain medicine) (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/01/18 at, 1:55 p.m., when asked about Resident 16 experiencing pain, Unlicensed Staff N stated Resident 16 did have some pain in her abdomen this morning when she was providing care. When asked if she reported the pain, Unlicensed Staff N stated she did not report the pain and, I just assumed the nurse already knew. When asked to whom she should report the pain, Unlicensed Staff N stated she would report resident's pain to a charge nurse. During an interview on 3/01/18, at 2:09 p.m., Resident 16 stated she received pain med, but the pain is getting worse, and she asked the nurse to call hospice. During an interview on 3/01/18, at 2:21 p.m., Licensed Staff E, stated Resident 16 was on hospice. Licensed Staff E stated she gave morphine 1 ml, 20 milligram, as needed every 4 hours, for Resident 16's abdominal 8/10 pain level at 2:05 p.m. When asked how often she assessed Resident 16's pain, Licensed Staff E stated assessing Resident 16's pain after giving pain medicine. Licensed Staff E stated Resident 16 started complaining of abdominal pain around 11 a.m. but Resident 16 was not due to receive pain medicine. Licensed Staff E stated she assessed Resident 16's abdomen by listening to Resident 16's bowel sounds. During a review of the clinical record for Resident 16, the Medication Administration Record for 3/18 indicated, Resident 16 received Morphine 20mg on 3/1/18 at 9:30 a.m., and the nurse document the result of Morphine was helpful at 10 a.m. The MAR indicated Resident 16 received Morphine 20mg on 3/1/18 at 2:05 p.m. Licensed Staff E stated Resident 16 had a prescribed Tylenol (pain medicine) for mild breakthrough pain, and the staff were to call hospice if Resident 16's pain medicine prescribed for severe could not control the pain. When asked if she called hospice for Resident 16, Licensed Staff E stated she would call hospice staff before the shift ends. During an interview on 3/05/18, at 4:03 p.m., Hospice Staff O stated Resident 16 had a lot of issues and over doing pain med. Hospice Staff O stated, We've had her (Resident 16) for years, on and off. Hospice Staff O stated the hospice physician changed Resident 16's Morphine 20mg from every two hours to every four hours, as needed, because Resident 16 would be unresponsive if she was getting a lot. During an interview on 3/05/18, at 4:36 p.m., Hospice Staff P stated, on 2/15/18, the Hospice Service started Resident 16 on low dose Methadone (synthetic, narcotic analgesic (pain reliever) and used for other medical purposes such as pain relief.) and changed the morphine from every two hours to every four hours. Hospice Staff P stated the facility requested to change the morphine because Resident 16 was falling from oversedation (reduction of anxiety, stress, irritability, or excitement by administration of a sedative agent or drug.). Hospice Staff P stated hospice nurse visits Resident 16 once a week, unless Resident 16 needed more hospice services. Hospice Staff P stated the facility staff should contact Hospice Service if Resident 16 reported increasing severity of pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/06/18, at 8:26 a.m., Resident 16 stated her pain goal was to get pain level down to 5, where she did not feel like screaming all the time. When asked how often staff were addressing her pain, Resident 16 stated, Nothing really gets done about it. 1-2 nurses seems to understand and care and the rest ignore you. You can't do anything just lay in there. I haven't been ok for a long time, I tried to act like I'm ok. I tried to smile. When asked how often she have to ask for pain medicine, Resident 16 stated, I don't think if I had it. I feel stupid if I asked and then they told you, 'you had one'. (It) doesn't really help if I had one or not. When asked if the pain medicine helps, Resident 16 stated, It doesn't seem to, I can't tell if had it or not, so obviously it does not help me much During an interview on 3/06/18, at 8:35 a.m., Licensed Staff E stated she have not given Resident 16's any medications yet. Licensed Staff E stated Resident 16 received morphine on 3/5/18 at 8:45 p.m. During an interview and concurrent record review on 3/06/18, at 4:53 p.m., when asked about a tool used to assess residents with pain, the Director of Nursing (DON) stated they used pain management that includes giving pain medicine like Norco (acetaminophen and hydrocodone), Morphine, Methadone, using distraction, hot pack, pain assessment using 1-10 pain scale if residents are alert and oriented, and checking for grimaces for non-verbal resident. The DON stated the Certified Nursing Assistant (CNA) would bring the information to the nurse, and the nurse would assess and do what they can to help. Regarding Resident 16's pain management, when asked how and when do staff try to identify circumstances in which pain can be anticipated, the DON stated Resident 16 started with certain amount of morphine and methadone and that they (Hospice Service) increased methadone to work long term better. The DON stated, She's (Resident 16) pretty good at telling us her pain. The DON stated the Hospice Service increased her long term (long-acting medication) so she doesn't get snowed (oversedated). The DON stated the facility put Resident 16 on Hospice Service because she likes getting extra attention as told by Resident 16 to the DON. When asked how often Resident 16's pain assessment was, the DON stated the staff should assess Resident 16's pain at the beginning of every shift, before medication, and report from other shift whether she had pain medication before. The DON stated the staff would call hospice service if Resident 16's pain appeared to be out of control, and the hospice staff could do another reassessment. When asked how staff communicates with the physician about the resident's pain status, current measures to manage pain, and the possible need to modify the current pain management interventions, the DON stated, Hospice is driving her care. When asked how the facility developed the interventions, the DON stated, the facility tried to convince her to get out of her room, to join activity, to put hot pack on shoulders, to rest, and for Resident 16 to lay on her back when sitting in wheelchair for too long. The DON stated, the facility performed conference care between Hospice Service and DON and worked conjunctively. When asked if any of Resident 16's interventions been effective, the DON stated, I think so, I don't think if she would agree with me. The DON stated Resident 16 had high tolerance of pain, that's why it's a work on progress. The DON stated, Her (Resident 16) favorite is every 1 hour pain med, even if you tell her, she forgets. The DON stated the facility have not tried communication board or visual reminders informing Resident 16 about her pain medicine. The DON verified Resident 16 Care Plan for Pain had no measureable goals, no measureable pain assessment frequency, and not Resident 16-centered. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	When the DON was informed Resident 16 waited for hours (from the time Resident 16 complaint of pain at 10: 46 a.m until she received pain medicine at 2: 05 p.m.) in pain until Morphine was due, the DON stated the staff should have call the Hospice Service if there was no pain medicine available. During a review of the clinical record for Resident 16, the Nurses Note, dated 12/18-2/15/18, had no documentation of Resident 16 being oversedated. During a review of the clinical record for Resident 16, the Palliative Care Form signed and dated by a physician on 11/14/16, indicated, The resident will require the frequent use of narcotic/anti-anxiety/hypnotic medications (treatment for pain, anxiety and sleeping problems) . The facility/agency will plan and implement measures to maintain the appropriate levels of medication for the resident to ensure comfort. During a review of the clinical record for Resident 16, the Resident Care Plan: Pain dated 12/17, indicated planned goals of Resident will verbalize/show decreased signs and symptoms of pain, and resident will require less pain medication to alleviate pain. The facility did not mark a pre-written planned goals indicating, Resident will achieve self-reported pain goal of (1-10):___; there was no written pain goal established. The planned approach indicated, Evaluate need for routine pain medication rather than PRN [as needed medication]. During a review of the clinical record for Resident 16, the Resident Care Plan: Palliative (specialized medical and nursing care that focuses on providing relief from the symptoms of pain, physical stress, and mental stress of a terminal diagnosis for people with life-limiting illnesses) dated 12/17, indicated a problem/need of use of narcotic/anti-anxiety/hypnotic medications (treatment for pain, anxiety and sleeping problems) with planned goal of Resident will be comfortable and pain free through terminal illness. The facility policy and procedure titled Pain Management dated 11/16, indicated, for Pain Assessment: The Interdisciplinary Team will develop a resident centered care plan for pain management, including non-pharmacological interventions. Goals for pain management and the acceptable level of pain relief will be determined in conjunction with the resident when possible. For Pain Management: Nurses will complete the Pain Flow Sheet for residents receiving PRN [as needed] pain medication to evaluate the effectiveness of the medication regimen .Nursing staff will implement timely interventions to reduce an increase in severity of pain .Nursing staff will also utilize non-pharmacological interventions to address possible issues contributing to pain . The facility policy and procedure titled Hospice Care of Residents dated 1/1/12, indicated, The resident's right to comprehensive pain and symptom management at the end of life, including but not limited to: Adequate pain medication. During a review of the Hospice Care Plan, provided by the facility on 3/13/18, the Care Plan for pain indicated to meet Resident 16's desired pain goal of 4/10. The facility policy and procedure titled Comprehensive Person-Centered Care Planning dated 11/17, indicated, The baseline care plan must reflect the resident's stated goals and objectives, and include interventions that address his or her needs.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 32860 32961 35842 37160 Based on observation, interview and record review, the facility failed to provide nursing care services for nine out of 68 residents (Resident 16, 8, 20, 62, 25, 39, 5, 29, and 48) based on residents' needs when the facility did not have sufficient numbers of staff. This failure resulted to residents not receiving personal care, assistance, supervision, and call light response in timely manner. Findings: During an interview, on 2/26/18, at 9:06 a.m., Resident 16 stated, they're always short with people. Resident 16 stated she had to wait between 3 to five minutes to an hour before staff would answer the call light because they did not have the help (person) you need. Resident 16 stated, If you can't get into the toilet, it's bad, you have to do it in your pants. No words to describe it. Put yourself where you're lying and you can't move. You have to go; you're trying to hold it. You're embarrassed. Resident 16 stated if you were already sitting in the toilet, you have to wait until someone comes. During a review of the clinical record for Resident 16, the Minimum Data Set (Resident assessment tool) dated 12/11/7, indicated Resident 16 needed an extensive assistance (resident involved in activity, staff provide weight-bearing support) with transfer and toileting. During an interview on 2/26/18 at 9:30 a.m., Resident 8 was asked if the facility had sufficient staff to care for the resident's needs. Resident 8 stated, yes they could use more CNAs (Certified Nursing Assistants) and nurses. When you need a shower here, you have to wait, because there is no one to cover the hall. During an interview on 2/26/18 at 10:45 a.m., Resident 20 stated, the facility was short staffed sometimes because the staff came and told me they were sorry for the wait, but we only have 3 (CNAs) tonight, or we only have 5 (CNAs) tonight. Resident 20 stated the workers here work a lot of double shifts, and the patients (residents) do a lot of waiting. During an interview on 2/26/18 at 11:00 a.m., Resident 62 stated, yes they could definitely use more CNAs (Certified Nursing Assistants). Resident 62 stated there was usually one CNA per hall, so when they take a break one CNA covers two halls. (continued on next page)

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	056361	A. Building B. Wing	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortuna Rehabilitation and Wellness Center, LP	2321 Newburg Road Fortuna, CA 95540

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/26/18, at 12:15 p.m., Resident 25 stated the staff responding to call light were So, so. I have to wait for a while to get an answer, 15 minutes and up. I needed to be up in bed. I'm having problem getting myself situated in bed, I need assistant to help me. It makes me upset, they take so long. I missed a shower two weeks ago. Resident 25 stated the facility was understaffed. Resident 25 stated, They're having short staff, 5 people (CNA) for the whole building that shouldn't happen. During an interview on 2/27/18, at 12:14 p.m., Resident 39 stated the staff were not very fast, half hour, at least half hour and you just wait and wait when for the staff to answer the call light. During a concurrent observation and interview on 2/28/18 at 2:10 p.m., Resident 5 was feeding herself a pureed diet. Resident 5's was positioned at a 45-degree angle while eating, napkin was not in place and food was all over Resident 5's clothes and blankets. There was no staff supervising Resident 5 while she was eating her meal. Resident 5's breathing sounded a little raspy after meal. Licensed Staff H stated Resident 5 did need assistance. Licensed Staff H stated the certified nursing assistant (CNA) would go between Resident 5 and Resident 38, but there was not enough staff to assist residents who were eating in their room and in the assisted dining room at the same time. Licensed Staff H stated the CNAs assisted the residents in the assisted dining room first and then the residents who wanted to eat in their room. During an interview on 3/1/18, at 4:56 p.m., Unlicensed Staff G stated usually she was assigned 11 residents for a work shift. Unlicensed Staff G stated of these 11 residents, eight residents were incontinent in bladder or bowel and six residents needed one person assist for transfers. Unlicensed Staff G stated she did not have enough time for providing resident care. During an interview on 3/6/18 at 10:00 a.m., Resident 29 stated it was not just the numbers of CNAs, but also the way they do their jobs. Resident 29 stated the CNAs came in, said, What do you need, turned the call light off, and then said, I will be right back. Resident 29 stated after waiting for more than one hour, he saw the same CNA in the hall passing his room, Resident 29 stated that he whistled to get the CNA's attention, the CNA had forgotten what he needed and/or hadn't told anyone else (i.e nursing if the request was for medications). Resident 29 stated he was just waiting to say that happens a lot here. During an interview on 3/06/18, at 3:45 p.m., Unlicensed Staff F stated depending on the resident load of the day, she missed bed making and missed giving showers. Unlicensed Staff B stated one more person (CNA) would be helpful. During an interview on 3/7/18 at 8:30 a.m., Licensed Staff B (who worked the night shift on 3/6/18) stated Resident 48 had tried to get up on his own and was found lying on floor by the CNA making rounds near the change of shift (AM of 3/7/17). Licensed Staff B stated the bed alarm did not go off because the battery was dead. Licensed Staff B stated Resident 48 had no injury. When Licensed Staff B was asked if there was enough nursing staff scheduled for 3/6/18 night shift, she stated a CNA had called in sick on night shift and she was assigned to 38 residents. Licensed Staff B stated there were 2 nurses and 3 CNAs scheduled last night for 68 residents. During an interview and record review on 3/07/18, at 9:03 a.m., the Administrator and DON, Director of Staff Development did not identify insufficient staffing to meet residents' needs. The DON stated they met the staffing hours of 3.33 per residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/7/18, at 9:22 a.m., the Staffing Coordinator stated for a census of 70 residents, they staffed 7-8 CNAs (certified nursing assistant) for AM (day) shift, 6-7 CNAs for afternoon/evening (PM) shift, and 3-4 CNAs for night (NOC) shift. The Staffing Coordinator stated a RNA (restorative nursing assistant) and a hydration aide, who did not usually have resident assignment, were included in the total number of CNA in AM and PM shift. The Staffing Coordinator stated each CNA took care of 11 -13 residents in all shifts (NOC shift each CNA had 17 to 24 residents, for a given 3- 4 CNAs to 70 residents). She stated they assigned residents to CNAs so each CNA had average number of rooms and residents. The Staffing Coordinator stated they also looked at acuity, which meant they would not assign all residents needing total care to one CNA. When asked how the CNA completed all the tasks and what tasks a CNA had to do for 11-13 residents, the Staff Coordinator itemized the routine tasks with time required as following: (the numbers in parentheses at the end of each task were used for calculation of the minimum minutes required for one work shift) * monitor residents: not able to define time needed * safety check: 5 minutes for all assigned residents (5) * shift change report: 15 -30 min (minutes) each shift change X 2 equaled to 30 - 60 min (30) * cleaning room: 15 min/resident x all (11 -13 residents) equaled to 165 - 195 min (165) * bathing: 15 -45 min/resident X 2 equaled to 30 - 90 min (30) * meals: 1 1/2 hour each meal/ AM x 2, PM x 1 (180 for AM, 90 for PM) * toileting: 10 - 20 min/resident x all (11 - 13 residents) equaled to 110 - 260 min (110) * grooming, shaving, glasses clean: 10 min/resident X 9 equaled to 90 min (90) * making beds: 5 min/resident x all (11 - 13 residents) equaled to 55 - 65 min (55) * feeding: included in meal time * setting up for tray in room or to dining room: included in meal time * vital sign: 10 min/CNA (10) * peri-care: included in toileting * drain catheter: included in toileting * call light answering: could not specify time * staff break: 15 min x 2 (30) * lunch: 30 minutes (30) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The calculation revealed; a minimum of 735 minutes were required to complete the routine tasks for 11 residents in one AM shift including breaks. These 735 minutes did not include the time for hand washing, answering call lights, monitoring residents, reporting change of condition, and other unexpected circumstances. One CNA had a total of 510 minutes per a given AM shift (8 hours shift plus 30 minutes lunch) including breaks, which were 225 minutes short for the staff to complete the minimum routine tasks. When asked how a CNA finished all these tasks timely and properly based on the given time and tasks, the Staff Coordinator stated it required time management. The Staff Coordinator stated she or the hydration aide would help out for the weak CNAs (who could not manage to finish the tasks or did not have good time management). When asked how a CNA could make up the additional 225 minutes required for completing the tasks, the Staff Coordinator stated, It is hard. The facility policy and procedure titled Communication-Call System dated 1/1/12, indicated, Nursing staff will answer call bells promptly, in a courteous manner. Upon responding to request, if item is requested is questionable, assistance will be obtained from the Charge Nurse. In answering to request, Nursing Staff will return to resident with the item or reply promptly. The Federal Regulation S483.35 Nursing Services, F725 (Standard of Operation Manual, Appendix PP) indicated, The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility ' s resident population in accordance with the facility assessment required at S483.70(e).

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 32860 Based on observation, interview and facility document review the facility did not provide residents with well balanced, palatable diets;when, Cook X did not follow recipes, Resident 66 complained about taste of food, and test-tray revealed an odd taste for a common food item. These failures may have contributed to reduced enjoyment of meals by residents. Findings: During a dining observation on 2/26/18 at 1:05 p.m., the menu read Taco Casserole (a substitute from 2 tacos with lettuce and tomato), Smoky Pinto Beans, Apple Crisp, and Milk. The observation of what was plated for resident was two large lumps of brown, thick substance, a small dish of pale yellow substance, with milk and coffee. No lettuce, tomato or any other vegitables was plated. It did not look palatable, and many residents did not eat much of it. During an observation and test-tray on 2/28/18 at 1:30 p.m., the menu was Old Fashioned Meatloaf w/gravy, AuGratin Potatoes, Peas, Parsley Garnish, Wheat Roll w/margarine, Orange Blossom Parfait, and Milk. The tray was plated and looked edible except the parfait which had no thickness to it. The parfait was watery enough to be poured into a cup and drunk. The meatloaf had an odd taste that made it taste sour. During an interview on 2/28/18 at 2:00 p.m., Cook X was questioned about following recipes and stated he put some oregano into the meatloaf to have it taste more Italian. The recipe for Old Fashioned Meatloaf did not call for oregano. Facility policy and procedure titled, Food Preparation, dated 2018, indicated: Policy: Food shall be prepared by methods that conserve nutritive value, flavor and appearance .Recipes are specific as to portion yield, method of preparation, amounts of ingredients, and time and temperature guide .Prepared food will be sampled .Poorly prepared food will not be served. Such food is to either be improved, prepared again, or replaced with an appropriate substitution.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 32860 Based on observations, interviews, and facility document review the kitchen did not have sufficient staff; when the Dietary Supervisor was tasked with prepping drinks and deserts for lunch, rather than supervise the staff utilized to prepare meals. This failure caused delays in food preparation and serving of meals. Findings: During an interview on 2/26/18 at 7:55 a.m., when tour was requested, Dietary Supervisor Y stated, Well I can't do it. I need to get these drinks out. We are short-staffed When Dietary Supervisor Y was asked who would give the tour Dietary Supervisor Y stated, I will do it. During observation on 2/28/18 at 10:55 a.m., Dietary Aide W was introduced as the staff member responsible for dishwashing. During an interview on 2/28/18 at 11:30 a.m., Dietary Supervisor Y stated, Someone quit and I'm training. My trainee is not up to speed yet. So I am filling in. During a concurrent interview and observation on 2/28/18 at 11:55 a.m., Cook X was walking from hot side of kitchen to cold side of kitchen 3 to 4 times. When questioned as to what he was doing, Cook X stated he was looking for a pan. He needed another pan and the dishwasher was on break. Dietary Aide W was assisting with placing drinks and condiments onto the trays. Cook X was observed searching for scoops, spatula, and a container for steamtable placement of pureed food, on the cold side where dishes had been washed but not put away. Review of facility document titled Meal Service Updated November 3, 2017, indicated: Lunch to 40's Hall at 12:30 p.m. The first cart left the kitchen at 12:50 p.m., and still needed to be checked by licensed nurse before going to 40's hall. Review of the facility document titled, I/C Morning Cook (given when job description for a.m. cook was requested), dated 3/30/17, indicated: .(14) Serve up lunch first cart goes out at 12:20.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 32860 Based on observation, interviews, and facility document review the facility did not honor Resident 66's preferences. This failure caused Resident 66 to dread meal time because she was unsure if it would be edible. Findings: During a dining observation on 2/26/18 at 1:05 p.m., the menu read Taco Casserole (a substitute from 2 tacos with lettuce and tomato), Smoky Pinto Beans, Apple Crisp, and Milk. The observation of what was plated for resident was two large lumps of brown, thick substance, a small dish of pale yellow substance, with milk and coffee. No lettuce, tomato or any other vegitables was plated. It did not look palatable, and many residents did not eat much of it. During an interview on 3/1/18 at 10:20 a.m., Resident 66 stated the concern with food was that it was tasteless, with undercooked scrambled eggs. When asked if she had spoken to Dietary Supervisor Y, Resident 66 stated it didn't do much good to talk to the kitchen staff. Resident 66 stated she had told them time and time again what she preferred. Resident 66 stated, I hate peas, but they keep serving peas on my plate. Resident 66 stated, They just feed me what they want to, it doesn't matter what I want. Resident 66 stated there were no fresh vegitables or salads most of the vegitables served came from a can, or they were not served at all. During an interview on 3/1/18 at 1:55 p.m., Dietary Supervisor Y stated that she encouraged her staff to go out and meet with the residents so they would get to know their likes and dislikes. The kitchen staff utilized a white board for likes dislikes, and a log book also for residents preferences. Dietary Supervisor Y, stated she also went out to talk with residents. When Dietary Supervisor Y was asked how she resolved complaints of not honoring requests, she did not answer. The facility policy and procedure titled Food Preferences, dated, 2018, indicated: Policy, Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from the appropriate food group .Procedure, Food preferences will be obtained as soon as possible through the initial resident screen. Assessment must be completed within 8 days of admission by the FNS Director. Food preferences can be obtained from the resident, family or staff members .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32860 Based on observations, interviews, and facility document reviews, the facility did not store, prepare, or distribute food in accordance with professional standards for food service safety, when; three dietary aides were not competent in sanitation fluid mixing or testing, Cook X was observed touching face, neck, hair, and continuing to prepare food without washing hands. Storage of canned, refrigerated, and frozen items was improperly dated. These failures had potential to cause cross-contamination and food borne illness in residents eating from the kitchen. Findings: During an observation and concurrent interview on 2/26/18 at 8:15 a.m., two boxes of stored canned goods were marked 3/23/18 as date received. Three refrigerated items, bell peppers, marked as received 4/18/18, rolls and cucumbers, marked as received 3/18/18. A box in the freezer of individual cups of ice cream was dated as received 3/18/18. The refrigerated and freezer items were in a box, with three fourths of the content gone yet had a future date as received. Dietary Supervisor Y was asked why the food was dated as received on a date that was not here yet? Dietary Supervisor Y stated, my staff just made a mistake when using the automatic date tool, they didn't read the date. During an observation and concurrent interview on 2/28/18 at 10:55 a.m., Dietary Aide W did not demonstrate knowledge of the process for manual three sink dishwashing process. Dietary Aide W was asked how long the dishes needed to be submerged in the sanitation solution, and responded not too long, I'm not sure, I don't do this too often, maybe 15 seconds. During an observation and concurrent interview on 2/28/18 at 11:45 a.m., Dietary Aide V did not demonstrate knowledge of the process for mixing the sanitation solution when the red bucket tested zero, no effectiveness, but had a dirty cloth inside it. Dietary Aide V was asked why the solution had no effectiveness. Dietary Aide V stated I'm very embarrassed. The solution needed to be changed. The solution was made when I got here this morning, it should have had some effectiveness. We change it every 2 to 3 hours and as needed. During an observation and concurrent interview on 2/26/18 at 1:40 p.m., Dietary Aide U did not demonstrate knowledge of the process for three compartment sink usage, or testing of the sanitation solution. Dietary Aide U was asked how long she needed to place dishes manually washed in the three compartment sink into the sanitizing solution. Dietary Aide U stated, after reading the posted three compartment information, 10 seconds. Dietary Aide U was asked to demonstrate sanitation solution in the dishwasher was effective. Dietary Aide U ran the dishwasher with one dish inside, removed the dish, and swabbed the dish (not the solution) to test for effectiveness. During an observation on 2/28/18 at 1:05 p.m., Cook X touched the back of his head, neck, and face and continued working on preparation of lunch without washing his hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy and procedure titled Handwashing dated 2018, indicated: Policy All employees will be instructed in the proper procedure of hand washing. Procedure: The FNS (Food and Nutrition Services) Director is responsible for the training of all Food & Nutrition Services employees. (proper hand washing procedure is under Section 10). Employee hands must be washed frequently in the hand washing sink . The facility policy and procedure titled Storage of food and Supplies dated 2017, indicated: Policy: Food and supplies will be stored properly and in a safe manner. Procedure: .Labels should be visible, and the arrangement should permit rotation of supplies so that oldest items will be used first. All food will be dated -- month, day, year . The facility policy and procedure titled Quaternary Ammonium Log Policy dated 2018, indicated: Policy: The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution. Procedure: The quaternary solution, used for sanitizing clean work surfaces in the kitchen, will be made according to the instructions on the product container or dispensing device set up for the specific quat product. The food & nutrition worker will place the solution in the appropriate bucket labeled for its contents and will test the concentration of the sanitation solution. The concentration will be tested at least every shift or when the solution is cloudy. The solution will be replaced when the reading is below 200 ppm. (parts per million). The replacement solution will be tested prior to usage. The readings will be recorded by the food and nutrition worker twice a day, once in the AM and once in the PM to document the process was completed . Review of the Competency Test dated, 1/18/18 for Dietary Aide U, and Dietary Aide V were un-scored and have different answers for the concentration of Quat. The Employee Performance Review dated, 2017, for Dietary Aide U, and Dietary Aide V were both incomplete.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 32860 37160 Based on observation and interviews, the administrator was aware of the heating system's inability to keep residents comfortable in the facility, and failed to act appropriately. This failure allowed residents to suffer with persistent temperatures that were uncomfortable for them, and put many of them at risk for hypothermia. (Cross Reference F 584). Findings: During an interview in the dining room on 2/27/18 at 8:30 a.m., Resident 29 asked if surveyor had a thermometer. When confirmed, Resident 29 stated, Could you take the temperature in here? The temperature read 67.1. Resident 29 stated, I'm freezing and the furnace has not been working for months . When complaint was made about it, the staff said the furnace was too old to get parts for it .They have given me three blankets for my bed, but I am still cold, especially at night. I think they should just buy a new one. During an interview on 2/27/18 at 11:30 a.m., Maintenance Supervisor was asked to provide documentation that the furnace was in working condition. The Administrator overhearing the conversation interrupted and stated, the boilers are working, but our boiler system cannot keep up with the severe weather. The temperatures in the last few weeks have dropped below freezing. During an observation and concurrent interview on 2/27/18 at 11:40 a.m., Maintenance Supervisor opened entry way to boiler room in the front hall of the building. There were 2 boilers inside. Maintenance Supervisor stated, these were new boilers, but that one operated at a time and the second was for a back-up in-case the first one failed. The second boiler room was located at the back of the building (in the 60's hall). After entering 2 doors a huge boiler system with cob-webs, rust around pipes, algie on the side of it was observed. An 8.5 by 11 inch sign titled, Boiler Failure Procedure was observed. Maintenance Supervisor stated that the boiler was very old and heated to a certain degree, then would shut off automatically. Maintenance Supervisor stated that the rooms in the 40's and 60's halls were at the end of the heat system, which caused the temperatures to drop in those areas. During an interview on 2/27/18 at 11:50 a.m., Administrator stated the temperatures were maintained in the facility between 64 to 74 degrees Fahrenheit. A review of facility document, provided by the facility, with no title and no date, on 2/27/18 at 11:50 a.m., the facility document indicated, Procedure 'comfortable and safe temperature' levels means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia or susceptibility to respiratory ailments and colds. Although there are no explicit temperatures standards for facilities certified on or before October 1, 1990, these facilities still must maintain safe and comfortable temperature levels . (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/27/18 at 12:05 p.m., Maintenance Supervisor was questioned regarding the sign titled, Boiler Failure Procedure and stated, when the boiler shuts itself off, this is the procedure we use to turn it back on again. On 2/27/18, at 1:47 p.m., the State Health Facilities Nurse Evaluators notified the Administrator and the DON of the Immediate Jeopardy. The Administrator stated, Where's the jeopardy? Our system can't handle this cold temperature. During an interview on 3/07/18, at 9:03 a.m., the Administrator stated the facility did not have preventative maintenance that oversees the boiler system (heating system). The facility policy and procedure titled Resident Rooms and Environment no date, indicated, Facility staff aim to create a personalized, homelike atmosphere, paying close attention to the following: .Comfortable levels of ventilation .Comfortable temperatures .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056361	A. Building B. Wing	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortuna Rehabilitation and Wellness Center, LP	2321 Newburg Road Fortuna, CA 95540

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35842 Based on interview and record review, the facility failed to ensure complete and accurate documentation of Resident 42's belongings upon her admission when the Resident's Clothing and Possessions document had no signatures or dates verifying all of Resident 42's clothing and belongings brought to the facility were inventoried and documented. This had the potential for Resident 42's belongings to get lost or not returned to her. Findings During a clinical record review for Resident 42, the Resident's Clothing and Possessions document had no signatures or dates verifying all of Resident 42's belongings and clothing's brought to the facility had been inventoried and documented upon admission. During an interview on 3/6/18 at 4:10 p.m., Social Services stated it was the RNA (Restorative Nurse Assistant) who was responsible for completing the Resident's Clothing and Possessions document upon the resident's admission and discharge. Social Services stated if there was no RNA scheduled for work that day, it would be the responsibility of the CNA (Certified Nurse Assistant). The facility policy/procedure titled, Residents Rights - Personal Property, revised 1/1/12, indicated resident's personal belongings and clothing are inventoried and documented upon admission

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37160 Based on interview and document review, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to: 1. Develop formal corrective action plans to address the facility's cold temperatures (Cross Reference F 584); 2. Develop formal corrective action plans or implement action plans to address insufficient staffing (Cross Reference F 725). These failures prevented the QAPI committee from implementing and evaluating an action plan to address facility cold temperatures and insufficient staffing. Findings: 1. During an interview and record review on 3/07/18, at 9:03 a.m., the Administrator and Director of Nursing (DON) did not identify and address residents' complaint of facility cold temperatures. The administrator stated the facility did not have preventative maintenance in place to keep the boiler system working properly to provide comfortable temperature. The administrator stated the QAPI committee did not have the facility cold temperature in their program until the Immediate Jeopardy was called. 2. During an interview and record review on 3/07/18, at 9:03 a.m., the Administrator and DON, Director of Staff Development did not identify and address of sufficient staffing to meet residents' needs. The DON stated they met the staffing hours of 3.33 per residents. The facility document titled QAPI Plan and Framework dated 11/22/17, indicated one the guiding principles: Our organization makes decision based on data, which includes the input and experience of caregivers, residents, health care practitioners, families, and other share holders. The Federal Regulation S483.35 Nursing Services, F725 (Standard of Operation Manual, Appendix PP) indicated, The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility ' s resident population in accordance with the facility assessment required at S483.70(e).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 32961 Based on observation, interview, and record review, the facility failed to maintain the sinks in two medication rooms in a sanitary condition. This failure resulted in the potential for cross contamination and infections. Findings: During a concurrent observation and interview on 2/28/18, at 4:02 p.m., in Station 2 medication room with Licensed Staff J, the sink inside the medication room had brown, green, and white substance covered the drain plug. Dust was noted in the sink. Licensed Staff J stated they did not use the sink. He stated the sink might not working. When Licensed Staff J turned on the faucet, water was running out from the faucet. The counter of the sink had some supplies including binders and papers. Licensed Staff L stated they used the counter but not for medication preparation. During a concurrent observation and interview on 2/28/18, at 4:50 p.m., in Station 1 medication room with the Director of Nursing (DON) and MDS (minimum data set) Coordinator, the sink inside the medication room had brown and green substance covered the drain plug. Dust was noted in the sink. The MDS Coordinator stated the sink was not working and they did not use it. When the DON turned on the faucet, water was running out from the faucet. The DON and MDS Coordinator stated they did not know the sink worked. The facility policy and procedure titled Storage of Medication, dated 10/07, indicated .Medication storage areas are kept clean, well lit, and free of clutter . The facility policy and procedure titled Infection Control dated 1/1/12, indicated, Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public.