| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056415 | A. Building<br>B. Wing | 07/21/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lynwood Post Acute Care Center | 3611 East Imperial Highway<br>Lynwood, CA 90262 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906<br><br>Based on observation, interview, and record review, the facility failed to protect the resident's right to a dignified existence and self-determination for one of one sampled residents (Resident 5) by:<br><br>1. Failing to answer Resident 5's call light and provide necessary care when the resident requested assistance to the restroom.<br><br>2. Failing to ensure all staff wore name badges that indicated employees name and title.<br><br>These deficient practices violated Resident 5's rights to be treated with dignity and respect and had the potential to negatively affect the resident's self-esteem and self-worth that can lead to psychosocial harm.<br><br>Findings:<br><br>1. During a record review of Resident 5's face sheet (admission record) dated 7/20/2022, the face sheet indicated the facility initially admitted Resident 5 on 6/21/2017 with diagnoses including hemiplegia (muscle weakness or partial paralysis [inability to move] on one side of the body that can affect the arms, legs, and facial muscles) following a cerebrovascular disease(conditions affect the brain) affecting the right dominant side. The face sheet indicated Resident 5 also had difficulty walking and abnormalities of gait and mobility.<br><br>During a review of Resident 5 ' s Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 4/28/2022, the MDS indicated Resident 5 ' s cognition (ability to think, make decisions, understand, learn, and make needs known) was intact and the resident was able to communicate clearly without any deficits. The MDS indicated Resident 5 was independent with eating; required supervision with walking in room and corridor, and required extensive assistance with bed mobility, dressing, transfer, personal hygiene, and toilet use.<br><br>During an observation upon entry to the facility on [DATE] at 11:02 a.m., the call light system display panel was observed in the nursing station. The lights and call signals were alarming indicating residents required staff for assistance.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a record review of the facility's Resident Council Minutes for the months of April and May of 2022, the minutes indicated the staff timely response to call lights was an issue.<br><br>During an interview with the Activities Director (AD) on 7/21/2022 at 11:19 a.m., the AD confirmed that for the months of April and May 2022, the residents complained of the call lights not being answered in a timely manner. The AD stated there was no specific length of time was mentioned but the residents requested staff needed to be more prompt in responding. The AD stated typical requests for assistance included requests for water and need for toileting assistance. The AD stated Resident 5 was one of the resident that complained about the call lights. Per the AD, the facility needed the issue addressed because meeting resident needs was very important.<br><br>During an interview with Resident 5 on 7/20/2022 at 9:26 a.m., Resident 5 stated staff poor response to call lights was an ongoing issue. Resident 5 stated twenty (20) minutes was the longest time she had to wait for her call light to be answered. Resident 5 stated she was the president of the resident unit council so it was also her responsibility to advocate for her fell ow residents. Resident 5 stated among other things, residents needed toileting assistance and have had incontinence (loss of bladder control) accidents due to poor staff call light response times.<br><br>During a record review of Resident 5's care plan titled, Needing assistance with activities of daily living ([ADL] daily tasks related to personal care, the plan indicated Resident 5 needed assistance with ADLs was at risk for falls, further decline in function, developing pressure ulcer and complications related to right hemiplegia secondary to general weakness.<br><br>Interventions included having the call light within reach and answered promptly.<br><br>During a record review of the facility's policy and procedure (P/P) titled, Answering call lights (undated), the P/P indicated the purpose of this procedure was to ensure timely responses to the resident's requests and needs. The P/P indicated If the residents' request was something staff can fulfill, complete the task within five minutes if possible. If uncertain as to whether or not a request can be fulfilled or if you cannot fulfill the residents' request the staff need to ask the nurse supervisor for assistance.<br><br>2. During an observation on 7/20/2022 at 11:45 a.m., the medical records assistant was observed not wearing a identification badge.<br><br>During a concurrent observation and interview with Licensed Vocational Nurse 3 (LVN 3) on 7/20/2022 at 12:52 p.m., LVN 3 confirmed she did not have an employee badge. LVN 3 stated she had been asking for a badge since she started in May 2022 to no avail. LVN 3 stated she needed a badge and all staff needed a badge so residents, visitors, and staff knows your identity and title. LVN 3 stated it could affect the residents' dignity. LVN 3 stated call lights needed to be answered promptly. LVN 3 stated call lights needed to be answered within a minute because it was very important to the residents. LVN 3 stated residents could be soiled or wet and need assistance and sitting on soiled undergarments can definitely affect the residents self-esteem and self-worth.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview with the Director of Staff Development (DSD) on 7/21/2022 at 1:51 p.m., the DSD stated employees needed to wear their badge so residents can identify the nurses. The DSD stated if licensed nurses had no identification badges the residents would not be able to identify the person taking care of them and the resident had the right to know. DSD stated call lights needed to be answered immediately for everyone. The DSD stated not answering call light timely and responding to residents' needs could be detrimental. The DSD stated the resident could sustain injuries and residents could be left dirty. Per DSD, the staff should change residents as much as possible and as needed when dirty.<br><br>During an interview with the Director of Nursing (DON) on 7/20/2022 at 1:57 p.m., the DON stated identification badges needed to be worn by staff at all times. The DON stated call lights needed to be answered promptly so resident needs can be met.<br><br>During a record review of facility's policy and procedure (P/P) titled, Identification Name Badges (undated), the P/P indicated to promote safety and security measures each employee must wear his/ her identification badge at all times while on duty.<br><br>During a record review of facility P/P titled, Dignity (revised 2/2021), the P/P indicated each resident shall be cared for in a manner that promoted and enhanced their sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P/P indicated demeaning practices and standards of care that compromised dignity were prohibited. Per policy staff was expected to promote dignity and assist residents-- for example promptly responding to a resident's request for toileting assistance.<br><br>44055 |

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| F 0757<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906<br><br>Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 1) was free from unnecessary drugs when the facility failed to:<br><br>1. Assess and monitor Resident 1 for side effects and adverse reactions for use of multiple central nervous system (CNS) depressants (medicines that treat insomnia [difficulty sleeping], anxiety [extreme worry], panic attacks [sudden episode of intense fear and triggers severe physical reactions when there is no real danger], seizures [sudden uncontrolled electrical disturbance of the brain]) and opiates (substance used to treat pain have serious side effects and serious risks).<br><br>These deficient practices resulted in Resident 1's mental, physical and psychosocial decline and becoming unresponsive, lethargic (a condition marked by drowsiness and an unusual lack of energy and mental alertness) and was transferred and admitted for nine days to a general acute care hospital (GACH) for opioid ([narcotic] class of drugs that is primarily used for pain relief) overdose (medical emergency occurs when you take more than the normal or recommended amount of the medication, symptoms may include shallow breathing, confusion, lessened alertness, and loss of consciousness).<br><br>Findings:<br><br>During a record review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and re- admitted on [DATE]. Resident 1's diagnoses included unspecified dementia without behavioral disturbance (group of thinking and social symptoms that interferes with daily functioning), unspecified fracture of upper end of right tibia, subsequent encounter for closed fracture without routine healing, chronic kidney disease (your kidneys are damaged and can't filter blood the way they should).<br><br>During a record review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 5/14/2022, the MDS indicated Resident 1 had clear speech, and was able understood and/or understand others. The MDS indicated Resident 1 required limited assistance with a one-person physical assist with bed mobility, personal hygiene, transfer, and locomotion on and off the unit, and extensive assistance with dressing, bathing, and toilet use.<br><br>During a record review of Resident 1's History and Physical (H/P) dated 5/17/2022, the H/P indicated the resident had the capacity to understand and make decisions.<br><br>During a record review of Resident 1's general acute care hospital (GACH) Emergency department (ED) provider notes dated 5/27/2022 at 9:22 p.m., the ED note indicated Resident 1 was brought in by ambulance from the facility for shortness of breath for an unknown amount of time. Upon arrival, resident oxygen saturation (test to see if breathing is fine) was 77 % on room air (normal range is 95 % to 100%). Resident 1 receives morphine (opioid [strong medication that treats moderate to severe pain]) extended release and Norco (pain medication that also contains opioid) for a recent lower extremity surgery. Clinical impression indicated final diagnoses to include acute and chronic respiratory failure (when person cannot breathe) with hypoxia (body not getting the needed oxygen), cough, aspiration pneumonia (when food or liquid is breathed into the airways or lungs, instead of being swallowed) and opioid overdose.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a record review of Resident 1's GACH Records, the records indicated on 5/27/2022 at 10:41 p.m., Resident 1 received Narcan (medication used to treat narcotic overdose in an emergency) one milligram ([mg] unit of measurement), woke up and became responsive. Resident 1 was discharged from the GACH on 6/6/2022 at 6:32 p.m. diagnosed with morphine (opioid, pain medication) intoxication (receiving too much medication), aspiration pneumonia, and schizophrenia (a serious mental disorder in which people interpret reality abnormally).<br><br>During an interview on 7/20/2022 at 11:37 a.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated when Resident 1 took pain medication, the license nurses need to perform an assessment pre and post administration of the pain medication. LVN 1 stated he asked Resident 1 where and what was the pain level and documented on the MAR to support why the resident needed pain medicine. LVN 1 stated that he was the one who gave the scheduled pain medicine on 5/27/2022 with a zero out of ten ([0/10] used to describe having no pain (0) to greatest level of pain (10) on a pain scale) pain level since it was scheduled medicine.<br><br>During an interview on 7/22/2022 at 10:30 a.m. with LVN 5, LVN 5 stated when Resident 1 was admitted to the facility the desk (licensed) nurse, Director of Nursing or MDS nurse completes the resident's admission and verifies the order with the physician. LVN 5 stated she was not aware of the admission process or who verified the medication from the hospital.<br><br>During a record review of Resident 1's care plan dated 5/5/2022 , the care plan titled, Alteration in comfort secondary to acute/chronic pain related to right tibia/fibula (broken tibia-fibula is a fracture in the lower leg that happens when a fall or blow places more pressure on the bones than they can withstand) status post open reduction and internal fixation (ORIF- is a type of surgery used to stabilize and heal a broken bone), indicated interventions to monitor for altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, respiratory distress, and sedation. The care plan further indicated to observe for adverse reactions with every interaction with the resident.<br><br>During a record review of the Resident 1's pain assessment dated [DATE], the assessment indicated there was no scheduled pain medication ordered.<br><br>During a record review of Resident 1's Physician's Orders dated 5/27/2022, the order indicated the following pain medications were started on 5/19/2022:<br><br>1. Morphine sulfate ER tablet extended release 30 milligrams ([mg] unit of measurement), one (1) tablet by mouth one time a day, hold if respirations (breaths) less than 12.<br><br>2. Gabapentin (used to treat nerve pain) tablet 600 mg, one tablet by mouth two times a day, hold if respirations less than 12.<br><br>3. Cyclobenzaprine hydrochloride (muscle relaxant used to treat pain muscle spasms) 5 mg, one tablet by mouth two times a day.<br><br>4. Hydrocodone-Acetaminophen ([Norco] narcotic used to treat mild to severe pain) tablet 10-325 milligrams, one tablet by mouth, every 6 hours as needed (PRN).<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 1's Medication Administration Record, for the month of May 2022, the MAR indicated Resident 1's pain level was assessed for each pain medication as ordered. The MAR indicated there was thirty-three (33) instances where the pain level was a zero (0) which meant no pain and the pain medication was still administered to Resident 1 as follows:<br><br>1. Morphine sulfate ER tablet extended release 30 mg, one (1) tablet once daily administered at 9 a.m. There were six (6) instances that Resident 1 stated she had no pain and medication was still administered from 5/20/2022 to 5/27/2022.<br><br>2. Cyclobenzaprine hydrochloride 5 mg, one tablet, administered twice daily at 9 a.m. and 9 p.m. Pain scale was zero (no pain), fourteen (14) instances and medication were administered from 5/19/2022 to 5/27/2022.<br><br>3. Gabapentin tablet 600 mg, one tablet by mouth, administered twice daily at 9 a.m. and 9 p.m. There were twelve (12) instances where pain level was zero and the resident was medicated with this pain medication, from 5/20/2022 to 5/27/2022.<br><br>4. Hydrocodone-Acetaminophen tablet 10-325 milligrams, one tablet by mouth. Pain was zero in one (1) instance on 5/25/2022 at 5:50 p.m. and medication was still administered to Resident 1.<br><br>During a record review of Resident 1's Nursing Progress Notes, the progress notes indicated the following:<br><br>a. On 5/25/2022, indicated that per endorsement from previous shift charge nurse reported Resident 1 was talking to herself and having episodes of restlessness. Prescribed Xanax (used to treat anxiety and panic disorders) was given and endorsed. 11-7 a.m. shift nurse entered room and the resident accused the nurse of attempting to crawl into her window and reality orientation provided but ineffective. Resident 1 continues to point to an imaginary window and talking to self.<br><br>b. On 5/26/2022, indicated that LVN heard screaming and Resident 1 stated that she was dreaming about the time she was in the hospital.<br><br>c. On 5/26/2022, Nurse Practitioner ([NP] an advanced practice registered nurse) increased dose of Olanzapine ([antipsychotic] used to treat mental disorders) 5 mg twice daily and discontinued Seroquel ([antipsychotic] used to treat mental disorders).<br><br>d. On 5/27/2022, Cough medicine administered as for productive cough.<br><br>e. On 5/27/2022 at 8:44 p.m., Resident 1 was noted to be lethargic and difficult to arouse.<br><br>Emergency medical services (EMS) 911 ambulance responded to the scene and transferred Resident 1 to a GACH.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a record review of the black box warning details for Resident 1's ordered morphine sulfate extended release, dated 5/12/2022, the warning indicated Risks from concomitant (reaction) use with benzodiazepines or other central nervous system ([CNS] brain and spinal cord, controls most functions of the body and mind) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing of morphine and benzodiazepines (depressants which slow down the body and brain's functions that produce sedation and hypnosis, used to relieve anxiety and muscle spasms) or other CNS depressants for use in patients for whom alternative treatment options are inadequate. Limit dosages and durations to the minimum required. Follow patients for signs and symptoms of respiratory depression and sedation.<br><br>During a record review of the Consultant Pharmacist's (CP) Medication Regimen Review (MRR) for the month of May 2022, the MRR indicated that muscle relaxants such as cyclobenzaprine are not recommended in the elderly due to their anticholinergic (drugs that block involuntary muscle movements and various bodily functions) side effects. The PC recommended that Resident 1, who had an order for routine Gabapentin and Morphine, with Norco and Tramadol as needed due to increased risk of Gabapentin as potentiators (used to enhance the action of a medication) for opioid- related adverse events, needed to reevaluate the drug regimen.<br><br>During an interview on 7/22/2022 at 10:05 a.m. with the Pharmacy Consultant (PC), PC stated that if there was an interaction with the medication upon admission, the pharmacy who received the order would send a drug review regimen. PC stated that Resident 1 was an elderly with renal failure (loss of kidney function) so the central nervous system depressant can make the resident confused, altered level of consciousness, and agitated. PC stated that it was still up to the physician if they want to discontinue or continue with the medicine. PC stated the pharmacist's main responsibility was to check and recommend medications. PC stated that the physician should have also caught that there was multiple psychiatric and opioid medications which was a strong cocktail medication that could make elderly residents confused or can affect mental behavior. PC stated that even before she visited the facility NP and or MD should have also reviewed the medication list and pharmacological management should have been done.<br><br>During an interview on 7/22/2022 at 11:28 a.m. with the Pharmacist (Pharm) 1, Pharm 1 stated that upon admission whichever pharmacist that received the medication list would go through the medication and if they (pharmacist) noted any discrepancies, the pharmacy would contact the physician and ask if they want to continue or discontinue the said order.<br><br>During an interview on 7/22/2022 at 11:25 a.m. with the Director of Nursing (DON), DON stated upon admission when the resident comes with psychotropic medicine the licensed nurse would have it referred to the Psychiatrist's Nurse Practitioner (NP) who comes to the facility to review and check if the medications are necessary. The DON stated the NP would review all medicine and if there were side effects from other medicine, it was up to the NP to discontinue or continue the medicine. The DON stated the NP should have caught that Resident 1 was having increased confusion and hallucinations because of opioid side effect instead of just increasing and adding psychotropic medication or anti-anxiety medication. DON further stated that there was no black box warning in the system. DON stated that since it was a scheduled pain medicine, even if Resident 1 was not experiencing pain, the nurses could still administer the medicine. DON further stated there was no change of condition reported to Resident 1's physician for increased agitation or increased hallucinations on 5/25/2022.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a record review of the Resident 1's Medication Administration Record (MAR), for the month of May 2022, the MAR indicated a black box warning was attached to the Morphine Sulfate order on the medication administration record.<br><br>During a record review of Resident 1's bubble packs for Norco 10 mg/ 325 mg, Morphine Sulfate extended release 30 mg, and Xanax 0.5.mg, dated 5/19/2022, the bubble packs indicated there was a caution black box warning sticker attached as an alert precaution.<br><br>During a record review of the Resident 1's care plan dated 5/5/2022, the care plan indicated that opioid analgesic risk evaluation and mitigation strategy (REMS) were to ensure that the benefits of opioid analgesics (medications used for pain relief) outweigh the risks of addiction, abuse and misuse, the Food and Drug Administration ([FDA] federal agency responsible to protecting and promoting public health through the control and supervision of prescription and over the counter medications) has required a Risk Evaluation and Mitigation Strategy ([REMS] a drug safety program required for certain medications with serious safety concerns to help ensure the benefits of the medication outweigh its risks) for these products. Under the requirements of the REMS, drug companies with approved opioid analgesic products must make REMS-compliant education programs available to health care providers. Health care providers are strongly encouraged to complete a REMS- compliant education program and counsel patients and/ or their caregivers, with every prescription, on safe use, serious risks, storage, and disposal of these products, emphasize to patients and their caregivers the importance of reading the medication guide every time it is provided by their pharmacist and consider other tools to improve patient, household, and community safety.<br><br>During an interview on 7/22/2022 at 3:24 p.m. with Nurse Practitioner (NP), NP stated that she comes to the facility to evaluate residents and manage their medication to stabilize their behaviors. NP stated residents that were already receiving pain medication when they were admitted was difficult to change or manage their medication because they were drug seekers. NP stated that she browsed Resident 1's medication list, but she never looked at the effect of the morphine sulfate for change of behavior. NP stated Resident 1 hallucinated when she was first admitted to the facility. NP stated that she did not manage any pain medicine or review any side effects. NP stated she only focused on the resident's behavioral and psychiatric problems. NP stated that dual psychotropic medicine was given to Resident 1 due to cross titration (increasing a dose over time) with the other medicine for behavioral management.<br><br>During a record review of Resident 1's GACH discharge summary dated 6/6/2022 at 4:16 p.m., the discharge summary indicated Resident 1's discharge diagnoses included morphine intoxication, aspiration pneumonia, and schizophrenia.<br><br>During a record review of the facility's policy and procedure (P/P) dated 12/2016 and titled, Antipsychotic Medication Use, the P/P indicated that the physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences.<br><br>During a record review of the undated facility's P/P titled, Pain- Clinical Protocol, the P/P indicated that the staff and physician will evaluate how pain is affecting the mood, activities of daily living, sleep, and the resident's quality of life, as well as how pain may be contributing to complications such as gait disturbances, social isolation, and falls. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906<br><br>Based on interview and record review, The facility failed to ensure one of one sampled resident (Resident 1) was adequately monitored for psychotropic drug (any medication that affects brain activities associated with mental processes and behaviors) use, as evidenced prior to initiating Olanzapine (is a second-generation antipsychotic [medication used to treat schizophrenia [mental health problem in which people interpret reality abnormally] bipolar disorder [ mental health problem where resident exhibits unusual shifts in moods and energy level]), Xanax (sedative[medication used to treat anxiety[excessive worry]), Lexapro (medication used to treat depression and anxiety) and Seroquel (is an atypical antipsychotic indicated for the acute and maintenance treatment of schizophrenia, bipolar disorder and as an adjunctive treatment to antidepressants in adults with Major Depressive Disorder[mental health disorder characterized by persistent sadness and/or loss of interest in activities once enjoyed]) by not ensuring:<br><br>1. The facility obtained documented evidence of an informed consent (process in which resident or responsible party [RP] was given information including possible risks and benefits of the treatment to help them decide if they want the treatment or not) obtained from the resident.<br><br>2. The facility thoroughly assess Resident 1 for possible side effects of opiod overdose.<br><br>The facility failed to develop and implement a personalized care plan (provides direction to nurses on the type of nursing care the individual needs) to guide nurses for the specialized care required for residents on these medications.<br><br>These deficient practices had the potential to result in Resident 1 experiencing undue adverse effects related to the use of psychotropic medications including, but not limited to drowsiness, dizziness, dry mouth, constipation, increased risk of fall, tardive dyskinesia (a medical condition causing involuntary movements), or death.<br><br>Findings:<br><br>During a record review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and re- admitted on [DATE]. Resident 1 ' s diagnoses included unspecified dementia without behavioral disturbance (group of thinking and social symptoms that interferes with daily functioning), schizophrenia, unspecified fracture of upper end of right tibia, and subsequent encounter for closed fracture (broken bone) without routine healing.<br><br>During a record review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 5/14/2022, the MDS indicated Resident 1 had clear speech, and was able to understood and/or understand others. The MDS indicated Resident 1 required limited assistance with a one-person assist with bed mobility, and personal hygiene, transfer, and locomotion on and off the unit, and extensive assistance with dressing, bathing, and toilet use.<br><br>(continued on next page) |

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|---|---|---|---|
| | 056415 | A. Building<br>B. Wing | 07/21/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lynwood Post Acute Care Center | 3611 East Imperial Highway<br>Lynwood, CA 90262 |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a record review of Resident 1 ' s History and Physical ( H/P) dated 5/17/2022, the H/P indicated the resident had the capacity to understand and make decisions.<br><br>During a record review of Resident 1 ' s order summary report dated 5/27/2022, the report indicated the following:<br><br>Lexapro Tablet 20 milligrams (mg), give one (1) tablet by mouth one time a day for depression manifested by verbalization of sadness: MD obtained informed consent: Risk and benefits explained. Start dated 5/13/2022.<br><br>Olanzapine tablet 5 mg, give 1 tablet by mouth two times a day for Schizoaffective/Bipolar disorder manifested by racing thoughts/ aggressive impulses: MD obtained informed consent Risk and benefits explained. Start date 5/26/2022.<br><br>Seroquel tablet 25 mg 1 tablet at bedtime for schizophrenia manifested by auditory/ visual hallucination. Start date 5/13/2022.<br><br>Xanax 0.5 mg give one tablet by mouth every q 12 hours as needed for anxiety manifested by restlessness. Start date 5/17/2022.<br><br>During a record review of Resident ' s 1 medical chart, no consent was found for the Seroquel, Lexapro and Xanax. Olanzapine medication consent was found, but was not signed by Resident 1's physician or the resident.<br><br>During an interview on 7/20/2022 at 11:31 a.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated that when residents receive psychotropic medication an informed consent, assessment and care plan should be in place prior to administering anti-psychotropic medication.<br><br>During an interview on 7/20/2022 at 12:05 p.m. with LVN 2, LVN 2 stated that licensed nurses are responsible in obtaining informed consent from the resident or responsible party (RP).<br><br>LVN 2 stated the nurses were the ones explaining the risks and benefits to the residents. LVN 2 stated that to be able to administer psychotropic, anti-anxiety and anti- depressant medication, nurses should verify the physician's order, ensure the consent was signed, care plan was initiated and the resident was assessed why the medication was needed. LVN stated depending on the whether the resident's behavior was worsening or improving, nurses initiated a change of condition (COC).<br><br>During an interview on 7/20/2022 at 12:45 p.m. with LVN 2, LVN 2 stated that there was no consent and no care plan for Seroquel, Xanax, and Olanzapine. LVN 2 stated that it was not right to give psychotropic medication without consent because it was considered a chemical restraint. LVN 2 stated it was important to get the consent especially with psychotropic medication because we might be giving medication the resident does want to take especially Resident 1 who was alert and oriented.<br><br>During an interview on 7/20/2022 at 12:5 5p.m. with the Director of Nursing, DON stated that every time there was a new psychotropic medication, especially if increasing the dose, a consent was needed. DON stated that there was no consent found or a care plan for Resident 1's psychotropic medication and anxiety medication.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 7/23/2022 at 3:30 p.m. with the Nurse Practitioner (NP), NP indicated that she does not get consent from the resident. NP stated it was the facility ' s responsibility. NP stated that she only explains risk and benefits when she prescribes medication like the Olanzapine, NP added that Resident 1 has been on multiple psychtropic medications since admission.<br><br>During a record review of Resident 1 ' s progress note dated 5/25/2022, the progress notes indicated that per endorsement from previous shift charge nurse, the charge nurse reported Resident 1 was talking to herself and having episodes of restlessness. The note indicated Resident 1's prescribed Xanax was given and endorsed. 11-7 shift nurse entered room and was accused of attempting to crawl into Resident 1's window and reality orientation provided but ineffective. Resident 1 continues to point to imaginary window and taking to self.<br><br>During a record review of the Consultant Pharmacist ' s Medication Regimen Review (MRR) for the month of May 2022, the MRR indicated that Resident 1 had a dementia disorder and was receiving Olanzapine and Seroquel. The MRR indicated that according to the Food and Drug Administration (FDA), the FDA warns that antipsychotics are associated with an increased risk of mortality in elderly individuals with dementia disorders.<br><br>During an interview on 7/22/2022 at 10:05 a.m. with the facility's Pharmacy Consultant (PC), PC stated that if there was interaction with the medication upon admission, the pharmacy that received the order would send a drug review regimen. PC stated Resident 1 was elderly with renal failure so the central nervous system depressant can make the resident confused, altered level of consciousness, and agitated.<br><br>During a concurrent interview and record review on 7/22/2022 at 11:05 a.m. with the DON, DON stated there was no change of condition found in Resident ' s 1 medical chart. DON stated that it was his expectation that nurses should do change of condition every time a resident had some changes like cognition, behavior, or anything not normal like coughing or diarrhea.<br><br>During a record review of Resident 1 ' s progress notes dated 5/26/2022, the progress notes indicated that Resident 1 was on one to one ([1:1] close monitoring) during the shift because of anxiety disorder.<br><br>During an interview with on 7/22/2022 at 11:25 p.m. with the DON, DON stated that usually alert residents like Resident 1 would not want to have 1:1 because of her privacy and Resident 1 would become ballistic about it. DON stated that upon admission, he usually referred residents to the Psychiatrist for behavioral issues and the Nurse Practitioner (NP) comes here every week to evaluate the resident. DON stated the NP should be the one explaining risks and benefits to the residents who are taking psychotropic medication and the NP should obtain consent and check other medication for any interactions that could possibly affect the resident ' s change in cognition.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 7/22/2022 at 3:24 p.m. with Nurse Practitioner (NP), NP stated that she comes to the facility to evaluate residents and manage their medication to stabilize their behaviors. NP stated residents that are already receiving pain medication when admitted to the facility was difficult to change or manage their medication because they are drug seekers. NP stated that she did browse Resident 1's medication list, but she never looked at the effect of the Morphine Sulfate for change of behavior, NP stated Resident 1 had hallucinations when she first came to the facility to begin with. NP stated that she does not manage any pain medicine or review any side effects. NP stated she only focuses on behavior and the psychiatric problems of the residents. NP stated that dual psychotropic medicine was given to Resident 1 due to cross titration with the other medicine for behavioral management.<br><br>During a record review of Resident 1's GACH discharge summary dated 6/6/2022 at 4:16 p.m., the discharge summary indicated Resident 1's diagnoes included morphine intoxication, aspiration pneumonia, and schizophrenia.<br><br>During a record review of the facility ' s policy and procedure (P/P), dated 12/2016, the P/P indicated that residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a resident ' s behavior, mood, function, medical condition, specific symptoms and risks to the resident and others. The attending physician will identify, evaluate, and document, with input from other disciples and consultants as needed, symptoms that may warrant the use of antipsychotic medications. The attending physician and facility staff will identify acute psychiatric episodes and will differentiate them from enduring psychiatric conditions.<br><br>Based on interview and record review, The facility failed to ensure one of one sampled resident (Resident 1) was adequately monitored for? psychotropic drug (any medication that affects brain activities associated with mental processes and behaviors) use, as evidenced prior to initiating Olanzapine (is a second-generation antipsychotic [medication used to treat schizophrenia [mental health problem in which people interpret reality abnormally] bipolar disorder [ mental health problem where resident exhibits unusual shifts in moods and energy level]), Xanax (sedative[medication used to treat anxiety[excessive worry]), Lexapro (medication used to treat depression and anxiety) and Seroquel (is an atypical antipsychotic indicated for the acute and maintenance treatment of schizophrenia, bipolar disorder and as an adjunctive treatment to antidepressants in adults with Major Depressive Disorder[mental health disorder characterized by persistent sadness and/or loss of interest in activities once enjoyed]). |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906<br><br>Based on interview and record review, the facility failed to ensure licensed nurses did not document a total of thirty (30) erroneous entries on one of one sampled residents (Resident 1's) Medication Administration Record (MAR) on 5/27/2022 during the 11:00 p.m. to 7:00 a.m. (Night) shift and on 5/28/2022 during the 7:00 a.m. to 3:00 p.m.(Day) shift while the resident was hospitalized .<br><br>This deficient practice had the potential for poor continuity of care.<br><br>Findings:<br><br>During a record review of Resident 1 ' s Admission Record (Face Sheet), [NAME] behavioral disturbance (groue Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and re- admitted on [DATE]. Resident 1 ' s diagnoses included unspecified dementia withop of thinking and social symptoms that interferes with daily functioning), schizophrenia (mental disorder where resident has a distorted interpretation of reality) , unspecified fracture of upper end of right tibia (broken bone of the lower leg), subsequent encounter for closed fracture (broken bones) without routine healing.<br><br>During a record review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 5/14/2022, the MDS indicated Resident 1 had clear speech, was able to understood and/or understand others. The MDS indicated Resident 1 required limited assistance with a one -person physical assist with bed mobility, and personal hygiene, transfer, locomotion on and off the unit, and an extensive assistance with dressing, bathing, and toilet use.<br><br>During a record review of Resident 1's Transfer Form dated 5/7/2022 at 8:24 p.m., the form indicated Resident 1 was transfered to an acute care hospital (ACH) after a change in condition.<br><br>During a review of Resident 1's Emergency Department (ED) notes from the ACH dated 5/27/2022 at 9:22 p. m., the ED notes indicated Resident 1 was brought in from the facility via ambulance and was admitted to the ACH for further evaluation.<br><br>During a record review of Resident 1's Medication Administration Record (MAR) for the month of May 2022, the MAR indicated Licensed Vocational Nurse (LVN) 5 charted Resident 1 receivedthe following ten (10) medications on 5/28/2022 at 9:00 a.m.:<br><br>1. Gabapentin (pain management) 600 milligram ([mg] unit of measurement), one(1) tablet (tab).<br><br>2. Docusate sodium (medication to soften stool) 100 mg two (2) tabs.<br><br>3. Benzonatate (for cough) 100 mg one (1) capsule (cap).<br><br>4. Seroquel (for schizophrenia [mental illness] manifested by visual and auditory hallucination (seeing and hearing something that is not there) one (1) tablet of 25 mg.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5. Olanzapine (schizoaffective/bipolar disorder [mental problem] manifested by racing thoughts/ aggressive impulses) one (1) tablet of 5 mg by mouth.<br><br>6. Morphine sulfate (pain medication) tablet extended release 30 mg, 1 tablet by mouth.<br><br>7. Lexapro (for depression [mental problem characterized by extreme sadness or loss of interest] manifested by verbalization [NAME] sadness) one Tablet 20 mg by mouth.<br><br>8. Cyanocobalamin Solution (supplement), 1000 microgram injection subcutaneously (to the skin).<br><br>9. Cyclobenzaprine (pain medicine) one tablet of 5 milligrams by mouth.<br><br>During a record review of Resident 1's MAR for the month of May 2022, the MAR indicated Resident 1 was monitored for the following behaviors and exhibited no behaviors on 5/27/2022 during the 11:00 to 7:00 a.m. shift, as documented by LVN 6, and as documented by LVN 5 on 5/28/21022 during the 7:00 a.m. to 3:00 p. m. shift.<br><br>1. Monitor behaviors(s) of auditory/ behavior visual hallucination every shift for use -of Seroquel.<br><br>2. Monitor for behaviors oof racing thoughts/ aggressive thoughts every shift for use of Olanzapine.<br><br>3. Monitor for behaviors of verbalization of sadness every shift for use of Lexapro.<br><br>4. Monitor side effects and adverse reactions for use of Olanzapine : Tardive dyskinesia (facial longue movement), Cognitive/Behavior impairment (decreased mental status), Akathisia (inability to sit still), Parkinsonism (tremors, drooling rigidity)unsteady gait, extrapyramidal symptoms ([EPS] shuffling gait, rigid muscle, shaking) frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia (inability to sleep), loss of appetite, weight loss, muscle cramps every shift.<br><br>5. Monitor side effects and adverse reactions for use of Seroquel : Tardive dyskinesia (facial longue movement), Cognitive/Behavior impairment (decreased mental status), Akathisia (inability to sit still), Parkinsonism (tremors, drooling rigidity)unsteady gait, extrapyramidal symptoms ([EPS] shuffling gait, rigid muscle, shaking) frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia (inability to sleep), loss of appetite, weight loss, muscle cramps every shift.<br><br>6. Monitor side effects for Lexapro every shift. Signs like Nausea and vomiting, anxiety, sexual dysfunction, insomnia, dizziness, weight loss or gain, tremors, sweating, drowsiness, fatigue, dry Mouth, diarrhea, constipation, headaches, increased risk for falls, fractures.<br><br>7. Monitor signs and symptoms of COVID 19 (highly contagious infection) such as fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea every shift.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a record review of Resident 1's MAR for the month of May 2022, the MAR indicated the following vital signs documented on 5/28/2022 at 4:13 a m by LVN 6:<br><br>a. Blood pressure (BP)= 115/77 millimeters of mercury (mm Hg).<br><br>b. Temperature= 97.1 degrees Fahrenheit.<br><br>c. Pulse=79 beats per minute.<br><br>d. Respirations= 18 breaths per minute.<br><br>e. Oxygen saturation= 97 percent.<br><br>During a record review of Resident 1's MAR for the month of May 2022, the MAR indicated the following vital signs documented on 5/28/2022 at 9 a m by LVN 5:<br><br>a. pain scale= zero (from scale of 0 to 10 and zero is no pain and 10 is worst pain).<br><br>During a concurrent interview with LVN 5 and record review of Resident 1's MAR on 7/22/2022 at10:58 a.m., LVN 5 confirmed Resident 1 was transferred to an ACH on 5/27/2022 at 8:24 p.m. LVN 5 then reviewed Resident 1's MAR for 5/2022, and noted that she had signed that she gave medications, had vital signs, and documented monitoring of Resident 1's behaviors. LVN 5 admitted she made a mistake and documented on Resident 1 on 5/28/2022 7:00 a.m. to 3:00 p.m. shift unknowingly. Per LVN 5, LVNs need to be more careful and not be so distracted while working.<br><br>During an interview with the Director of Nursing (DON) on 7/22/2022 at 11:51 a.m., the DON stated that he was just made aware of staff errors. The DON stated erroneous documentation was unacceptable. The DON stated, Why would you document on someone who was not there. The DON stated he already counseled LVN 5 and he would conduct in-services to ensure that staff will be more careful.<br><br>During a review of facility's job description for the Director of Nursing, the job description indicated the DON would manage, develop, and direct the overall operation of the nursing department in accordance with current federal, state, and local standards that govern the facility, and as directed by the Administrator and Medical Director.<br><br>44055 |