STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056415	A. Building B. Wing	05/11/2021

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39028 Based on observation, interview, and record review facility failed to treat three of 4 residents (2, 18, 173) with respect and dignity. Resident 2 and 18, who needed assistance from staff for activities of daily living (a term used in healthcare to refer to people's daily self-care activities) were not assisted and their call lights either were tuned off without it being answerer or not answered in a timely manner. The deficient practice of turning off the call lights without answering them or not answering them in a timely manner for Resident 2 and 18 could result in the residents not receiving the assistance they needed. Resident 173, used urinals (a plastic bottle that male residents uses to urinate) but the two half full urinals were stored on the resident's bedside table, close to the water pitcher. The deficient practice of not storing urinals away from the bedside table and away from the water pitcher had the potential for Resident 173 to mistakenly drink the urine, spill it on the beside table, which could result in cross contaminations. Findings: a. A review of Resident 173's Admission Face sheet indicated the resident was originally admitted to the facility on [DATE], the Admission Face sheet indicated Resident 173's diagnoses included type 2 diabetes mellitus (abnormal blood sugar levels), mild cognitive impairment, and altered mental status. A review of Resident 173's Minimum Data Set (MDS), an assessment and care-screening tool, dated 4/28/21, indicated the resident had mildly impaired cognitive (do not have full capacity to understand or to be understood by others) status for daily decision making. The MDS assessment indicated Resident 173 required assistance from staff with bed mobility, transferring to and from bed, chair or a standing position, moving from one location to another, dressing, eating, toilet use and personal hygiene. A review of Care Plans dated 4/22/21, failed to indicate a formulated plan of care for Resident 173 that addressed the needs for assistance from staff for activities of daily living (ADL) specifically targeted to resident's care in the facility. (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 - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 137's History and Physical assessment dated [DATE] indicated the resident had the capacity to understand and make decisions. A review of Resident 173's Bowel and Bladder Assessment form dated 4/22/21, indicated Resident 173 was occasionally incontinent (did not have control) of bladder function. The assessment indicated the resident continued to utilize the urinal at bedside, accidents and spillage of urine at times and able to feel the urge when needed to urinate. A review of Resident 173's physicians order dated 4/22/21, indicated Furosemide (medicine that increases urination) tablet 40 milligram (mg) 1 tablet by mouth one time a day for heart failure. A review of Resident 173's Medication Administration Record dated 5/2021, indicated the resident was actively receiving furosemide tablet 40 mg, 1 tablet by mouth one time a day for heart failure. On 5/7/21 at 12:04 P.M., during facility tour and observation there were two half full urinals were placed on Resident 173's bedside table, close to the water pitcher. During an interview with the director of nursing (DON) present in the resident's room who confirmed the urinals on the bedside table. The DON stated the urinals were not supposed to be there because it could spill or the resident could accidentally drink urine in place of water, which could cause infections. The DON stated Certified Nursing Attendants (CNA) were supposed to conduct rounds every hour to check on the residents. The DON stated by placing the urinals on the bedside table meant no body had checked on the residents. During interview Resident 173 stated the urinals were not supposed to be placed on his table but he needed to urinate and could not hold it any longer. The resident stated either that or he would have to wet the bed because the medications made him urinate more frequently. On 5/7/21 at 1:44 P.M. during observation and interview CNA 2 stated the residents urinal were not supposed to be left on the bedside table to avoid spills, and cross contamination. CNA 2 stated it was the duty of all staff to ensure they made rounds every hour to check on the resident's care area. CNA 2 stated I was not able to make rounds on Resident 173 on time. On 5/10/21 at 01:35 P.M. during interview the Infection Preventionist (IP) nurse stated the urinals were supposed to be kept on the bed rails and not on the bedside table. IP nurse stated I have witnessed urinals placed on bedside table in the residents room. I replaced it on the bedside rails and informed resident that it is cross contamination putting urinals on bedside table. If it is full resident can call the nurses to empty it. A review of facility's policy and procedure titled Quality of Life-Dignity, dated 2/2020, indicated the residents are treated with dignity and respect at all times. The policy indicated the staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment. The policy indicated demeaning practices and standards of care that compromise dignity are prohibited. staff are expected to promote dignity and assist residents. The policy indicated to promptly responding to a resident's request for toileting assistance. A review of facility's policy and procedure titled Activities of Daily living, dated 3/2018, indicated the residents will be provided with care, treatment and services to ensure that their maintain or improve activities of daily living do not diminish unless the circumstances of their clinical condition demonstrate that diminishing ADLs are unavoidable. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41489 b. During a review of Resident 18's Admission Records indicated the resident was initially admitted on [DATE] and readmitted on [DATE]. The Admission Records indicated Resident 18's diagnoses included unstable angina (condition which the heart does not get enough blood flow and causes unexpected chest pain), chronic obstructive pulmonary disease (group of diseases that block airflow and make it difficult to breathe), and cardiomegaly (condition in which the heart is enlarged). During a review of Resident 18's Minimum Data Set (MDS), a resident assessment and care-planning tool, dated 3/26/2021 indicated Resident 18 had no cognitive (thought) impairment for daily decision making. During a review of the Resident Council minutes dated 3/9/2021 indicated Resident 18 voiced grieved regarding her call lights not being answered in a timely manner. During an interview on 05/06/21 at 09:02 a.m. Resident 18 stated I have access to my call light. When I use the call light, sometimes the nurses come in and tell me they will come back because they are helping someone else. This problem happens on all shifts. I usually need my diaper change because I'm incontinent. Sometimes I wait about 30 minutes because the nurses forget to comeback. During a concurrent interview and observation on 05/06/21 at 10:05 a.m., Resident 18 pressed her call light. During the observation a green light above Resident 18's room turned on. However, there was no audible alarm sound to alert the staff. During the observation seven staff members were observed passing Resident 18's room without responding to the call light. During the same observation at 10:15 a.m. the call light was answered by a Restorative Nurse Assistant (RNA). The RNA stated Everyone is responsible for answering the call light. There's a light that goes off at the nurse's station and a beeping noise. If someone passes a resident's room and the green light is on then they are supposed to answer the call light. We answer the light and we try to assist them but if we are busy with other residents we are supposed to ask for assistance. We should not tell the resident to wait. We should take care of them right away. c. During a review of Resident 2's Admission Records indicated the resident was initially admitted on [DATE] and readmitted on [DATE]. The Admission Records indicated Resident 2's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis of one side of the body), muscle weakness, type 2 diabetes (abnormal blood sugar levels), and seizures (bursts of uncontrolled electrical activity in the brain that causes abnormalities in muscle tone or movements). During a review of Resident 2's Minimum Data Set (MDS), a resident assessment and care-planning tool, dated 4/25/2021 indicated Resident 18 had no cognitive (thought) impairment with daily decision making. During a review of the Resident Council minutes dated 4/13/2021 indicated Resident 2 commented her call lights were not being answered in a timely manner. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/06/21 at 10:38 a.m., Resident 2 stated My call lights are still not answered on time. This happens on all the shifts. I waited about an hour 3 times this week for the nurses to come. I had to use my phone to call the receptionist. I need help to move from the bed to the bedside commode. They come in and shut off the light like if they helped me. All of my CNA's do this. They come in I tell them I have to use the bathroom and they turn off the light and then go find the nurse. At night they sit at the desk and don't answer the call light. During an interview on 05/07/21 at 10:38 a.m., CNA 9 stated We are short CNA's about 3 to 4 times a week in general. We need more CNA's because we end up getting extra patients. It effects the residents care at times. Today we have 9 CNA's and we are good but sometimes we have 5 CNA's and that is not enough. Any staff can answer a call light. If a call light is going off any staff who sees it should enter the resident's room and check. Sometimes when we are short nurses, we can not answer the call light on time. Sometimes I am busy and I answer the call light I let the resident know I will come back because I am busy. If I'm busy I must ask to for help. It only takes about 5 or 10 min to come back, but when we do not have enough nurses we really can not get to everyone. During an interview on 05/07/21 at 11:12 a.m., CNA 8 stated Anyone can answer a call light. No one should pass up a call light. Sometimes I see nurses pass up call lights. They will answer the lights now just because you are here. The LVN's do not answer the call lights. Some do. Residents complain about call lights not being answered. This is the first time I see the nurses doing their job. I don't ask for help because no one wants to help. We don't have enough CNA's. We use registry at times. This is the first week all of the nurses have all been here. Sometimes when I come in the mornings the schedule is not ready so we don't always know who our residents are. The LVNs make the schedule. When we are fully staffed, we should have 10 CNA's sometimes we have from 4 to 7 CNAs working. During an interview on 05/10/21 at 10 a.m., the Director of Staff Developer (DSD) stated We have complaints of residents not having call lights answered at times. All staff should answer call light. No one should pass up a call light. The resident's issue should be addressed right away. If the staff is busy, they should call someone else to help. The residents should not have to wait at all. They should be assisted right away. No one should have to wait 5 to 10 minutes for a call light to be answered. During an interview on 05/10/21 at 12:15 p.m., CNA 10 stated I feel overwhelmed at times. Sometimes I need help but can't get it. It effects answering call lights because we don't have enough nurses to answer the call lights. Sometimes the residents complain that it takes too long to get help. At times I have seen nurses walk pass call lights without checking on the Residents. A review of the facility's policy and procedure (P/P) titled Answering the Call Light, revised March 2021 indicated When answering call lights, if the resident needs assistance, indicate the approximate time it will take for you to respond. If the residents request is something you can fulfill, complete the task in less than 5 minutes if possible. If you are uncertain as to whether a request can be fulfilled or if you cannot fulfill the resident's request. Ask the nurse supervisor for assistance. If assistance is needed when you enter the room, summon help by using the call signal.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36394 Based on observations, interview, and record review the facility failed to provide a homelike environment for two of 2 residents (8, 56). Resident 8, who was using a low air loss mattres ([LALM] designed to prevent and treat pressure wounds) was soaked and stained with dark brown material and had an odor of concentrated urine. The deficient practice resulted in an unpleasant odor that permeated in Resident 8's room. Resident 56 had boxes on top of boxes filled with personal belongings, which was placed on the floor close to the bed. The deficient practice created a harzadous environment for Resident 56. Findings: a. On 05/05/21 at 11:53 a.m., observed Resident 8, awake and oriented to name, place, and time. The resident was lying in a bed that was covered with a LALM. The LALM was soaked and stained with dark brown material and had an odor of concentrated urine. During interview Resident 8 stated the LALM had never been cleaned or changed. The resident stated she had asked the maintenance department to clean or replace the existing LALM with a new one. A review of Resident 8's admission record indicated the resident was admitted to the facility on [DATE], with diagnoses that included pressure ulcer (sores extend below the subcutaneous fat into your deep tissues like muscle, tendons, and ligaments) of the right hip stage 4 (full thickness tissue loss with exposed bone, tendon or muscle with slough or eschar may be present on some parts of the wound bed). A review of of Resident 8's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/14/2021, indicated the resident had no cognitive impairment (ability to think, understand and make daily decisions) with daily decision making. On 05/06/21 at 11:06 a.m., during an interview with the Housekeeping Supervisor (HS) stated curtains and LALM had to be washed once a month but deep cleaning had not been performed due to Covid-19 pandamic. HS stated individual rooms were cleaned but there were no documented evidence. HS stated LALM had to be disinfected for 5 to 10 minutes and left to air dry which was done on a monthly or as needed basis if soiled but could not provide any documented evidence. b. On 05/06/21 at 10:19 a.m., during observation Resident 56 was in bed awake and oriented. The resident had boxes on top of boxes filled with personal belongings, which was placed on the floor close to the bed. According to the Resident 56 her belongings should have been properly arranged into her closets but no one was willing to do it. The observation of the cluster and hazardous environment was acknowledged and confirmed by the maintenance supervisor who said I agreed the belongings should have been arranged into boxes to create home like environment A review of Resident 56's admission record indicated the resident was admitted to the facility on [DATE], with diagnoses that included hypertension (high blood pressure). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of of Resident 56's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/22/2021 indicated the resident had no cognitive impairment (ability to think, understand and make daily decisions) for daily decision making.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39028 Based on interview and record review the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) of non-coverage, and Notice of Medicare Provider Non-coverage (NOMNC) form to three of 3 residents (4. 12, 30). The deficient practice of not providing advanced notice for last day of coverage ABN-SNF form, and notice of Medicare part A non-coverage indicating Medicare was about to end, did not give Resident 4, 12, and 30 the right to appeal, which could result in denial of right and discharge from the facility. Findings: A review of Resident 4's Admission Face sheet indicated the resident was originally admitted to the facility on [DATE] and readmitted [DATE], and discharged [DATE]. Resident 4's diagnoses included type 2 diabetes mellitus (adult onset of elevated blood sugar levels) , muscle weakness, other abnormalities of gait and mobility. A review of Resident 12's Admission Face sheet indicated the resident was originally admitted to the facility on [DATE], and discharged [DATE]. Resident 12's diagnoses included,abnormal posture, urinary tract infection (UTI) Infection of the bladder, other abnormalities of gait and mobility. A review of Resident 30's Admission Face sheet indicated the resident was originally admitted to the facility on [DATE], and discharged [DATE]. Resident 30's diagnoses included type 2 diabetes mellitus (adult onset of elevated blood sugar levels) , other abnormalities of gait and mobility, and muscle weakness. On 5/8/21 at 10:54 A.M., during and interview and review of SNF Beneficiary Notification for Residents 4, 12, and 30 did not have supporting evidence to show the residents were notified of their rights. During an interview the Business Office Assistant and Accounts Receivable Resource personnel stated we have searched everywhere and could not locate NOM-NOC/ABN for the three residents, and we do not have any other evidence available to prove. A review of facility's undated policy and procedure titled Form Instructions of the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, indicated a. A medicare provider or health plan must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrolles receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. b. The NOMNC must be delivered at least two calendar days before Medicare covered services end, or the second to last day of service if care is not being provided daily. c. The provider must ensure that the beneficiary or representative sign and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disrupted.

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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** 43455 Based on interview, and record review, the facility failed to ensure the resident's Care Plans (a document outlining a detailed approach to care customized to an individual resident's need) include measurable objectives and timeframe to meet 12 of 21 residents (2, 7, 11, 25, 26, 32, 41, 42, 56, 57, 172, 173) resident's medical, nursing, and mental and psychosocial needs. Resident 2, 7, 11, 25, 26, 32, 41, 56, 57, 172, 173 who were prescribed insulin (a medication used to treat and regulate abnormal blood sugar) therapy were not adequately monitored for glycated hemoglobin ([HgA1c] blood test that tells the average level of blood sugar over the past 2 to 3 months) to ensure the Interdisciplinary Team ([IDT] involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities) in managing the resident's diabetes. Residents 2, 7, 11, 25, 26, 41, 57, 172, and 173 did not have routine HgA1c levels ordered to monitor the resident's goals and outcomes for the diagnosis of diabetes (a condition characterized by high levels of blood sugar which damage the heart, eyes and kidneys [pair of organs responsible for filtering waste materials out of the blood and passing them out of the body as urine, and regulating blood pressure of the body]) as per standard of practice. These deficient practices had the potential to cause Residents 2, 7, 11, 25, 26, 41, 57, 172, 173, to receive suboptimal (less than the highest standard or quality) care related to diabetes, to not know how their blood sugar (BS) levels were managed and if the current insulin therapy was adequate could lead to serious health complications such as damage to important organs such as the heart, kidneys, eyes and the nervous system. Residents 32 and 56, did not have resident centered Care Plans for hospice services or end of Life (palliation of a terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life). The deficient practice could lead to Resident 32 and 56 not receive the person-centered care needed. Resident 42, who was refusing the administration of Lovenox (blood thinner) did not have Care Plan formulated to address the refusals and to perform blood laboratory as ordered and report to the primary physician. However, the facility did not perform any labs during the duration of Lovenox therapy. Findings: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/11/21 at 10:33 AM, during a phone interview the Consultant Pharmacist (CP) stated she completes the Medication Regimen Review ([MRR] a thorough evaluation of the medication regimen) for all of the residents. The CP stated for the residents who were diagnosed with diabetes she made sure there were HgA1c blood levels ordered by the physician. CP stated she would make recommendations to the physician if the HgA1c were not ordered. The CP stated HgA1c levels should be ordered every three months and when the residents showed stable blood sugar levels then the blood test could be reduced to every six months. The CP stated that ordering HgA1c levels every three months was standard of practice, and a diagnostic tool to evaluate the effectiveness of therapy for the resident to determine if changes in medication therapy were necessary. The CP stated HgA1c levels above 8 percent (%) should be evaluated closely and routinely. On 05/11/21 at 11:02 AM, during an interview the Minimal Data Set Coordinator (MDS) stated HgA1c should be documented on how it need to be monitored as part of the residents' Care Plan. The MDS stated medical records department had not been tracking to ensure the residents had HgA1c orders but will do so going forward. The MDS stated diabetic (persons with diabetes) residents on insulin should have HgA1c levels checked every three months. The MDS stated HgA1c was important because it shows if the insulin therapy was effective for the resident and if any changes to the medications need to be made based on the levels obtained. The MDS stated that it was important to have the right medications for diabetic residents to make sure their BS levels are stabilized so that they do not have complications such as coma (a period of prolonged unconsciousness brought on by illness or injury), get hospitalized or die. The MDS stated all diabetic residents should have a baseline HgA1c when admitted to the facility and laboratory services did not stop working even during COVID-19 (highly contagious respiratory infection) pandemic (an infectious disease that has spread across a large region, for instance multiple continents or worldwide, affecting a substantial number of people). On 5/11/21 at 11:51 AM, during an interview the Director of Nursing (DON 2) stated HgA1c should be ordered at admission for diabetic residents and re-ordered every three months to know if the medications were working. The DON 2 stated the care plan for diabetes should include the monitoring for HgA1c. The DON 2 stated if BS levels were not checked and insulin doses not given then the residents could have low or high BS levels, which could lead to coma, hospitalization , sustain ketoacidosis (serious diabetes complication where the body produces excess blood acids), and even die. On 5/11/21 at 12:40 PM, during a phone interview the Medical Doctor (MD 1) stated she usually orders HgA1c levels and when she overlooks to order the level, she gets reminded by the CP. The MD 1 stated HgA1c should be ordered every three months and for stable residents it could be reduced to every six months or yearly thereafter. The MD 1 stated BS levels are not enough to determine effectiveness of the insulin medications that was why HgA1c level was needed to determine if changes in the insulin medications were needed. The MD 1 stated not having HgA1c levels for residents was a concern and should be part of their diabetes care plan. The MD 1 stated it was harmful for the residents when the BS level was not checked, or insulin orders not administered. a. During a review of Resident 2's Admission Record, dated 5/10/21, indicated that resident was initially admitted to the facility on [DATE] with a diagnosis of diabetes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 2's Medication Administration Record (MAR) for April and May 2021, indicated the resident was prescribed Insulin Lantus (type of insulin) 20 units (a measure of dosage for insulin) in the morning. The order indicated to hold if BS was less than 100 milligram per deciliter (mg/dL), on 4/7/21. The order indicated to administer Insulin Regular (type of insulin) as per sliding scale (insulin dose dependent on the BS level) subcutaneous (under the skin) before meals and at bedtime on 10/13/18. A review of Resident 2's undated Care Plan indicated to give diabetes medications as ordered by doctor and check fasting serum (liquid part of blood) BS as ordered by doctor. However, the Care Plan did not contain a plan on how and when to monitor the HgA1c levels. A review of Resident 2's clinical chart did not contain a record for HgA1c level physician order or laboratory results since admission on 6/21/17. On 5/11/21 at 4:00 PM, during an interview, MDS stated that, after a thorough search, Resident 2's HgA1c level physician order and lab results could not be found. b. A review of Resident 7's Admission Record, dated 5/10/21, indicated the resident was initially admitted to the facility on [DATE]. A review of Resident 7's Order Summary Report, dated 5/10/21, indicated the resident was prescribed Glargine (type of insulin) 5 units subcutaneous one time a day and to hold if BS was less than 100 mg/dL dated 3/18/21. The order indicated to administer Insulin Regular (type of insulin) as per sliding scale subcutaneous three times a day before (AC) meals and bedtime (HS) dated 4/6/21. A review of Resident 7's Care Plan dated 1/21/21 indicated to give diabetes medications as ordered by doctor. However, the Care Plan did not contain a plan to monitor for HgA1c levels. A review of Resident 7's clinical chart did not contain a record for HgA1c level physician order or lab results since admission 1/21/21. On 5/11/21 at 4 PM, during an interview MDS stated after a thorough search Resident 7's HgA1c level physician order and lab results could not be found. c. A review of Resident 11's Admission Record, dated 5/10/21, indicated the resident was initially admitted to the facility on [DATE] with a diagnosis of diabetes. A review of Resident 11's Order Summary Report, dated 5/10/21, indicated the resident was prescribed Basaglar Kwikpen (type of insulin) 20 units subcutaneous two times a day and to hold for BS less than 100 mg/dL dated 12/9/20 until 5/6/21. The order indicated to administer Lantus 20 units subcutaneous two times a day and to hold if BS was less than 100 mg/dL dated 5/6/21. The order indicated to administer Insulin Regular (type of insulin) as per sliding scale subcutaneous before meals and at bedtime dated 12/12/20. A review of Resident 11's Care Plan dated 10/10/20 indicated to give diabetes medications as ordered by doctor and to check fasting serum BS as ordered by doctor. However, the Care Plan did not contain a plan to monitor for HgA1c levels. (continued on next page)

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	056415	A. Building B. Wing	05/11/2021

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 11's clinical chart did not contain a record for HgA1c level physician order or lab results since admission. On 5/11/21 at 4 PM, during an interview MDS stated after a thorough search, Resident 11's HgA1c level physician order and lab results could not be found. d. A review of Resident 25's Admission Record, dated 5/10/21, indicated the resident was initially admitted to the facility on [DATE] with a diagnosis of diabetes. A review of Resident 25's Order Summary Report, dated 5/10/21, indicated the resident was prescribed Humulin R (type of insulin) as per sliding scale subcutaneous three times a day dated 3/2/21. A review of Resident 25's Care Plan dated 11/20/20 indicated to give diabetes medications as ordered by the doctor and to check the fasting serum BS as ordered by doctor. However, the Care Plan did not contain a plan to monitor for HgA1c levels. A review of Resident 25's clinical chart did not contain a record for HgA1c level physician order or lab results since admission. On 5/11/21 at 4 PM, during an interview the MDS stated after a thorough search, Resident 25's HgA1c level physician order and lab results could not be found. e. A review of Resident 26's Admission Record, dated 5/10/21, indicated the resident was initially admitted to the facility on [DATE] with a diagnosis of diabetes. A review of Resident 26's Order Summary Report, dated 5/10/21, indicated the resident was prescribed Lispro (type of insulin) as per sliding scale subcutaneous before meals and at bedtime dated 4/7/21. A review of Resident 26's Care Plan dated 4/7/21 indicated to give diabetes medications as ordered by doctor and check fasting serum BS as ordered by the doctor. However, the Care Plan did not contain a plan to monitor for HgA1c levels. A review of Resident 26's clinical chart did not contain a record for HgA1c level physician order or lab results since admission. On 5/11/21 at 4 PM, during an interview MDS stated after a thorough search, Resident 26's HgA1c level physician order and lab results could not be found. f. A review of Resident 41's Admission Record, dated 5/10/21, indicated the resident was initially admitted to the facility on [DATE] with diagnoses including diabetes. A review of Resident 41's Order Summary Report, dated 5/10/21, indicated the resident was prescribed Glargine (type of insulin) 5 unit subcutaneous two times a day and to hold if BS less than 100 mg/dL dated 9/14/20. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 41's Care Plan on 1/2/21 indicated to monitor BS by finger stick as per orders, notify MD of significant changes, and to administer oral medication and/or insulin per orders. However, the Care Plan did not contain a plan to monitor for HgA1c levels. A review of Resident 41's clinical chart did not contain a record for HgA1c level physician order or lab results since admission. On 5/11/21 at 4 PM, during an interview the MDS stated after a thorough search, Resident 41's HgA1c level physician order and lab results could not be found. g. A review of Resident 57's Admission Record, dated 5/10/21, indicated the resident was initially admitted to the facility on [DATE] with a diagnosis of diabetes. A review of Resident 57's Order Summary Report, dated 5/10/21, indicated the resident was prescribed Glargine (type of insulin) 15 units subcutaneous two times a day and to hold for BS less than 100 mg/dL dated 1/10/21. A review of Resident 57's Care Plan, dated 7/7/20 indicated to give diabetes medications as ordered by doctor. However, the Care Plan did not contain a plan to monitor for HgA1c levels. A review of Resident 57's clinical chart did not contain a record for HgA1c level physician order or lab results since admission. On 5/11/21 at 4 PM, during an interview the MDS stated after a thorough search, Resident 57's HgA1c level physician order and lab results could not be found. h. A review of Resident 172's Admission Record, dated 5/10/21, indicated the resident was initially admitted to the facility on [DATE] with a diagnosis of diabetes. A review of Resident 172's Order Summary Report, dated 5/10/21, indicated the resident was prescribed Glargine (type of insulin) subcutaneous at bedtime and to hold if BS less than 100 mg/dL dated 4/3/21. A review of Resident 172's clinical chart did not contain a record for HgA1c level physician order or lab results since admission. On 5/11/21 at 4 PM, during an interview the MDS stated after a thorough search, Resident 172's HgA1c level physician order and lab results could not be found. i. A review of Resident 173's Admission Record, dated 5/10/21, indicated the resident was initially admitted to the facility on [DATE] with a diagnosis of diabetes. A review of Resident 173's Order Summary Report, dated 5/10/21, indicated the resident was prescribed Humulin R (type of insulin) as per sliding scale subcutaneous before meals and at bedtime dated 4/22/21. A review of Resident 173's Care Plan dated 4/22/21 indicated to give diabetes medications as ordered by doctor. However, the Care Plan did not contain a plan to monitor for HgA1c levels. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 173's clinical chart did not contain a record for HgA1c level physician order or lab results since admission. On 5/11/21 at 4 PM, during an interview the MDS stated after a thorough search, Resident 173's HgA1c level physician order and lab results could not be found. A review of the facility's policy and procedure document titled Diabetes - Clinical Protocol, dated November 2020 indicated that: 1. For residents who meet the criteria for diabetes testing, the physician will order pertinent screening; for example, A1C, fasting plasma glucose, or 2-hour plasma glucose with oral glucose load. 2. As indicated, the Physician will order appropriate lab tests (for example, periodic finger sticks or A1C) and adjust treatments based on these results and other parameters a. Examples of blood glucose monitoring 1) . 2) . 3) For the resident receiving insulin who is well controlled: monitor blood glucose levels twice a day if on insulin .; monitor 3 to 4 times a day if on intensive insulin therapy or sliding scale insulin; . Monitor A1C on admission .or when diabetes is diagnosed , and every 6 months thereafter. 3. The Physician will order desired parameters for monitoring and reporting information related to blood sugar management. a. The staff will incorporate such parameters into the Medication Administration Record and care plan. 36394 j. A review of Resident 32's Admission Record Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included cancer, and hypertension (high blood pressure). A review of Resident 32's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/12/2021 indicated the resident did not have the capacity to understand and make decision. A review of the Hospice recertification form dated 4/5/2021 to 6/3/2021 indicated Resident 32 was readmitted to Hospice services due to cerebral infarction (stroke). A review of the Hospice binder for Resident 32 had blank care plan forms and blank comprehensive care plan forms. On 05/10/21 at 12:15 p.m., during an interview with the Director of Nursing (DON) stated the Hospice agency and the facility had to develop a an individualized care plan because care plan drove Resident 32's care. k. A review of Resident 59's admission Record (Face Sheet) indicated the resident was initially admitted to the facility on [DATE] and readmitted with diagnoses that included but were not limited to chronic kidney disease (inability of the kidney to function) and hyperkalemia (high potassium levels). A review of the Hospice recertification form dated 4/6/2021 to 6/4/2021 indicated Resident 59 was readmitted to Hospice services due to the diagnosis of chronic kidney disease (inability of the kidney to function). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Hospice binder for Resident 59 had blank care plan forms and blank comprehensive care plan forms. On 05/10/21 at 11:26 a.m., in a concurrent interview and record review with the MDS nurse stated the facility and Hospice agency did not develop a plan of care. The MDS nurse further stated not developing a plan of care for Hospice services could lead to the staff not be able to provide personalize care. The facility's policy an procedure titled Care Plan revised 2016 indicated a person-centered care plan shall be developed that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs. 39028 I. A review of Resident 42's Admission Face sheet indicated the resident was originally admitted to the facility on [DATE], The Admission Face sheet indicated Resident 42's diagnoses included laceration of unspecified part of colon, muscle weakness (generalized), other abnormalities of gait and mobility, and hypotension (low blood pressure). A review of Resident 42's Minimum Data Set (MDS), an assessment and care-screening tool, dated 3//21 indicated the resident had intact cognitive (had full capacity to understand or to be understood by others) skills for daily decision making. Resident 42 required supervision from staff with bed mobility, transferring to and from bed, chair or a standing position, moving from one location to another, dressing, eating, toilet use and personal hygiene. A review of Resident 42's History and Physical assessment notes dated 3/3/21 indicated the resident had the capacity to understand and make decisions. A review of Resident 42's Physician order dated 3/3/21, indicated to administer Aspirin enteric coated (barrier applied to oral medication that prevents its dissolution or disintegration in the gastric environment) tablet delayed release 81 milligram (mg), give 1 tablet by mouth one time a day for cerebral vascular accident (stroke) prophylaxis (prevention). The physician order dated 3/3/21, indicated to inject subcutaneous (under the skin) the Lovenox 30 mg/0.3 ml, inject 30 mg. A review of the Care Plans dated 3/3/21, indicated Resident 42 did not have Care Plan for the use of anticoagulant (blood thinner) therapy, Aspirin 81 milligram (mg) by mouth one time a day. A review of Care Plan dated 3/3/21, for Lovenox (blood thinner) therapy for deep vein thrombosis (a blood clot in a deep vein, usually in the legs) prophylaxis (prevention) indicated blood laboratory works as ordered, and monitor, document and report to the primary physician. However, the facility did not perform any labs during the duration of Lovenox therapy. On 5/8/21 at 10:17 A.M., during observation and interviews, Resident 42 stated the only issue I have in the facility is about the blood thinners I have been receiving since after my abdominal surgery. I do not know how long I am intended to take these medications and no one had explained to me. I have tried calling the doctor to explain the process but no answer. I spoke to the nurses and they do not answer my question. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/8/21 at 10:25 A.M., during interview Registered Nurse (RN 1) stated Resident 42 receives Lovenox and Aspirin therapy as result of abdominal surgery. RN 1 stated the resident refused the Lovenox most times and questions reason why and how long the therapy was to continue. During interview RN 1 stated the facility had not yet informed the prescribing physician about the resident's refusals. On 05/11/21 at 10:08 A.M., during record review of Pharmacy Medication Regimen Review (MRR) dated 4/1/21 and 4/29/21, indicated Resident 42 had been receiving Lovenox subcutaneous every 12 hours along with Aspirin 81 mg. The MRR notes indicated the Consultant Pharmacist recommended to re-evaluate the need for both Lovenox and Aspirin. The notes indicated this combination may lead to increased risk for bleeding and increasing clotting time. On 05/11/21 at 10:08 A.M., during MRR review the Pharmacy Consultant recommended Resident 42 Lovenox be monitored by conducting basic metabolic panel ([BMP] a group of 8 tests that measures several substances in the blood) and complete blood count ([CBC] a group of tests that evaluate the cells that circulate in blood) every 2 weeks while on the medication. However, the recommendations were not Care Planed as part of the goals and interventions. On 5/11/21 at 11:59 A.M. during record review and intermittent interview Licensed Vocational Nurse (LVN 1) stated the consultant pharmacist visits the facility at the beginning of each month to review every resident's medication, and the RN was supposed to follow up with those recommendations by notifying the physician. LVN 1 stated once the physician agreed with the recommendations the staff would follow up and ensure the order was carried out. LVN 1 stated in this case, there was no follow up of any kind and nothing had been done for Resident 42. The recommendations for BMP and CBC every 2 weeks while on Lovenox recommended by the Consultant Pharmacist had not been incorporated in the residents treatment. LVN 1 acknowledge that even though Resident 42 was receiving Lovenox and Aspirin at the same time, there were no Care Plan formulated for the use of Aspirin therapy. On 5/11/21 at 12:25 P.M., during interview Case manager (CM) stated the Pharmacy Consultant visits the facility beginning of the month and made recommendations. The CM stated she printed all recommendation and hand them over to the DON, and RN for follow up. CM stated she did not understand reason why there was no follow up with Resident 42's primary physician regarding the recommendations made by the Pharmacy Consultant. 05/11/21 at 12:35 PM during interview and record review MDS nurse stated I do the MDS and Care Plans. I omitted to Care Plan for the use of this medication for Resident 42. A review of facility's policy and procedure titled Care Plans, Comprehensive Person-Centered dated 12/2016, indicated the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive person-centered care plan for each resident. b. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. c. The comprehensive person centered care plan will identify the professional services that are responsible for each element of care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36394 Based on interview and record review the facility failed to ensure care plan for Fall risk Prevention, was revised with measurable objective and time frame after Resident 59 sustained a fall with head pain. This deficient practice had the potential of resulting to Resident 59 having another fall with serious harm or death. Findings: A review of Resident 59'S admission Record (Face Sheet) indicated the resident was initially admitted to the facility on [DATE] and readmitted with diagnoses that included but were not limitted to Chronic Kidney disease (inability of the kidney to function) and Hyperkalemia (high potassium levels). A review of Resident 59's Fall Risk Data Collection dated 2/5/2016, indicated a score 14 (a score of 10 or above represents high risk for falls. 8/10/2016, score of 13, 11/9/2016, score of 17 and 5/4/2021. The Fall Risk Datas indicated Resident 59 reuired assist in mobility with bowel and blader eliminations. It also indicated Resident 56 was on Diuretic (medication that increase uring out put), Narcotic's (pain medication) and antihypertensives (medication for blood pressure). A review of Resident 59's Minimum Data Set (MDS), an assessment and care-screening toolk, dated 4/16/2021, indicated Resident 59 had moderately impaired cognition skill (thought process) and totaly depended on staff for activities of daily living (ADLs). A review of Resident 59's Post care plan for Fall risk Prevention, dated 5/4/2021, indicated a discription on how the resident fell . Facility failed to indicate interventions that will address subsequent falls. Areview of Resident 59's nursing progress note dated 5/3/2021 at 23: 25 indicated the resident was found on the floor next to her bed on her right side (fetal position with her head resting upon the base of the bedside table. No indicated no injury but with previous multiple skin discolorations. Note indicated the facility did not complete the 72 hours charting, 72 hours even thogh the writer requested for but the facility did not provide and no x-ray of the head was ordered. On 05/06/21, 01:22 P. m., during an interview with LVN 7 stated interventions such as placing call light within resident reach, bed in a lower position, monitoring resident frequently due to resident having behavior, placing on 72 hours charting, obtaining x- ray, assess for pain and medicate but failed torevised the plan of care to reflict resident's needs. The facility's policy an procedure Care Plan revised 2016 indicated a person -centered care plan shall be developed that includes measureable objective and timetables to meet the resident's physical, psychosocial and functional needs . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	41489 Based on interview and record review the facility failed to revise and update the care plan for one of three sampled Residents (Resident 18) after the Resident was transferred to the General Acute Care Hospital (GACH) for chest pain and subsequently readmitted to the facility. This deficient practice had the potential for Resident 18 to not have her care plan goals met, not have additional interventions implemented to prevent further incidences of chest pain or to experience a decline in physical and mental health. Findings: During a review of Resident 18's Admission Record, it indicated the resident was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 18's diagnoses included unstable angina (condition which the heart does not get enough blood flow and causes unexpected chest pain), chronic obstructive pulmonary disease (COPD[group of diseases that block airflow and make it difficult to breathe]), and cardiomegaly (condition in which the heart is enlarged). During a review of Resident 18's Minimum Data Set (MDS), a resident assessment and care-planning tool, dated 3/26/2021, it indicated Resident 18 had no cognitive (thought) impairment. During a review of Resident 18's progress notes dated 3/26/2021 at 2:28 p.m. , the progress notes indicated Resident 18 was transferred to GACH via 911 for complaints of chest pain radiating to the left arm. The progress notes indicated Resident 18 stated it feels like sharp pain. The progress notes indicated three Nitroglycerin (medication given to treat and prevent chest pain) tablets were administered to Resident 18 but were ineffective. During a review of the facility's Nursing Home to Hospital Transfer Form dated 3/26/2021, the form indicated Resident 18 was transferred to GACH for com plaints of chest pain on 3/26/2021. During a review of Resident 18's GACH discharge summary dated 3/28/2021, the summary indicated Resident 18's admission diagnosis on 3/26.2021 was unstable angina and chest pain. The summary indicated Resident 18's discharge diagnosis on 3/28/2021 was atypical (unusual) chest pain, COPD, and persistent cough. During a review of Resident 18's physician orders dated 3/29/2021, the physician orders indicated Resident 18 to be readmitted to facility. During a review of Resident 18's care plan titled Risk for irregular pulse and chest pains secondary to history of hypertension(high blood pressure) and chronic heart failure (the heart does not pump blood as it should) indicated the care plan was initiated on 11/18/2020 and revised on 11/18/2020. The care plans goal risk for onset of chest pain will be minimized every day for 3 months was initiated on 11/18/2020 and revised on 5/3/2021. The care plan indicated the interventions to be implemented were initiated on 11/18/2020 and revised on 11/18/2020. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a interview and record review on 5/11/2021, at 11:09 a.m., LVN 5 stated We are supposed to update and revise care plans upon readmission, if there is a change of condition of a resident, new behavior, or a new medication for a Resident. LVN 5 acknowledged there were no updates or revisions to Resident 18's Risk for Chest Pain care plan after 3/26/2021. A review of the facility's policy and procedure (P/P),titled Care Plans, Comprehensive Person-Centered, revised December 2016, indicated the care plans are revised as information about the residents and the residents' condition change. The policy indicates the Interdisciplinary team (IDT[team of physicians , nurses, dietary, social services, and staff who work together the address the resident's needs]) must review and update the care plan when there has been a significant change in the Resident's condition, when the desired outcome is not met, when the Resident has been readmitted to the facility from a hospital stay, and at least quarterly.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36394 43455 Based on interview, and record review, the facility failed to provide quality nursing care (nursing care that results in desirable outcome and are consistent with current professional knowledge and practice) for 21 of 21 residents by failing to: 1. Monitor and document blood sugar (BS) levels on the Medication Administration Record (MAR) from 4/1/21 thru 5/10/21 for 21 of 21 residents (Residents 2, 6, 7, 10, 11, 25, 26, 32, 33, 35, 36, 41, 47, 52, 54, 57, 60, 61, 172, 173 and 322). 2. Administer and document insulin (medication used to regulate BS levels) doses on the MAR from 4/1/21 to 5/10/21 for twenty-one of twenty-one residents (Residents 2, 6, 7, 10, 11, 25, 26, 32, 33, 35, 36, 41, 47, 52, 54, 57, 60, 61, 172, 173 and 322) 3. Monitor HgA1c (a test that measures average BS levels over a three-month period) levels for 17 of 21 residents (Residents 2, 7, 10, 11, 25, 26, 32, 35, 36, 41, 47, 52, 54, 57, 172, 173 and 322) as indicated on the facility's Policy and Procedures, Diabetes-Clinical Protocol. These deficient practices of not monitoring and documenting BS levels, not administering and documenting insulin doses and not monitoring HgA1c levels, compromised the health of all 21 residents and had the potential to compromise the resident's health and increased the risk to experienced serious health complications such hyperglycemia (excess of sugar in the blood), coma (a prolonged period of unconsciousness brought on by illness or injury) and likely resulting in hospitalization or death. On 5/10/2021 at 4:09 p.m., the Administrator (ADMIN) and the Director of Nursing 1 (DON 1), were notified an Immediate Jeopardy ([IJ], a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called for the facility's failure to have a system in place for 21 of 21 residents from receiving scheduled and as needed (sliding scale) medications as prescribed by the physician. Monitor BS levels and HgA1C testing. The facility's ADMIN and DON 1 were notified of the potential for serious harm to all 21 residents and seriousness of the residents' health and safety being threatened. On 5/11/2021 at 3:25 p.m., the ADMIN was notified the IJ was lifted after review and on-site validation of the accepted Plan of Action (POA) via observations, interviews, and record review of the following: 1. On 5/10/21, Quality Assurance in-serviced all licensed nurses including registry nurses, regarding insulin administration using the facility's electronic computer record (PCC) to ensure that no insulin order has been omitted and performed accordance with physicians' orders and BS check on PCC as ordered. 2. All identified and affected residents were assessed by RN Supervisor on 5/10/21. No acute change in condition noted. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. On 5/10/21, all residents with diabetes records were reviewed to ensure HgA1c test result were available. Nine residents were identified to not have HgA1c test since admission, and six residents with HgA1c ([hemoglobin A1c] test that evaluates the average amount of glucose in the blood over three [3] months by measuring the percentage glycated hemoglobin in the blood) test more than three months old. 4. On 5/10/21, licensed nurses contacted the physicians for those residents and obtained orders to perform HgA1c test. Lab test performed, processed, and result received as of 5/11/21. Seven resulted HgA1c reviewed, and the physician notified of recent results. Physicians response and orders will be carried out and resident/Responsible Party (RP) notified for any changes. 5. Affected residents will be monitored for 72 hours for any changes in condition. Care Plan reviewed and interventions updated 5/11/21 and ongoing. 6. On 5/11/21, medical records department conducting audit for all residents with MD order for HgA1c and ongoing. 7. Ongoing licensed nurses including registry nurses in-service being conducted by the DON 2 and Director of Staff Development (DSD) on 5/11/21 on the following topic: review of Policy and Procedure on Diabetes Clinical Protocol, Insulin Administration and Medication Administration documentation, including but not limited to laboratory test order follow up with physician and RP notification. Completion date 5/14/21. 8. Medication Administration Record (MAR) will be audited by the medical records designee daily Monday to Friday to ensure that BS check and insulin administration recorded timely. The Registered Nurse (RN) Supervisor/Designee will check the PCC eMAR (electronic MAR) dashboard daily to ensure compliance. 9. Licensed nurses will check and monitor PCC eMAR during their shift to ensure complete and timely documentation. 10. The medical records department will maintain daily audit of laboratory results, for example, HgA1c Monday to Friday. Findings will be discussed during the daily morning meeting for further follow up and management. 11. The Consulting Pharmacist (Consulting Pharmacist) will maintain the monthly Medication Regimen Review (MRR) with emphases on assessing residents with Insulin order and on diabetic management. Follow up with physician, resident and RP notification for any treatment changes will be carried out by the licensed nurses. 12. Applicable Policy and Procedures reviewed on 05/11/2021, no changes made at this time. 13. The CP will monitor compliance with physicians' orders monthly and present a report to the DON2 and ADMIN. 14. The DON2 or designee will provide a summary trend analysis of findings to the monthly Quality Assurance and Performance Improvement ([QAPI] committee meeting for review and recommendations). If there are no negative findings reported after six months, issue is considered resolved. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Findings: a) During a review of Resident 2's Admission Record (Face Sheet), dated 5/10/21, the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE] with a diagnosis of diabetes (a condition characterized by high levels of BS which can lead to serious damage to the heart, eyes and kidneys [pair of organs responsible for filtering waste materials out of the blood and passing them out of the body as urine, and regulating blood pressure of the body]). During a review of Resident 2's Medication Administration Record (MAR), for the review periods of 4/2021 through 5/2021, the MAR indicated Resident 2 was prescribed Lantus 20 units in the morning, hold if BS less than 100, subcutaneously before meals and at bedtime and per sliding scale. Resident 2's MAR indicated that a total of 21 BS levels were not documented, seven (7) doses of Lantus were not signed as administered, and 18 doses of Humulin R as per sliding scale were not signed as administered to Resident 2. During a review of Resident 2's undated Care Plan titled, Diabetes Mellitus, dated 3/21/2021, the care plan indicated to give diabetic medications as ordered by the physician, and check fasting serum (blood) BS. b) During a review of Resident 6's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 6 was admitted to the facility on [DATE] with a diagnosis of diabetes. During a review of Resident 6's Order Summary Report, dated 5/10/21, the report indicated Resident 6 was prescribed Novolin R as per sliding scale subcutaneously before meals and at bedtime and Levemir 15 units subcutaneously two times a day and to hold for BS less than 100. During a review of Resident 6's Blood Glucose Monitoring ([BGM] - where the insulin doses and BS are documented) log between 4/1/21 and 5/10/21 indicated a total of 27 BS levels not documented, 12 doses of Levemir were not signed as administered, and 15 doses of Novolin R as per sliding scale were not signed as administered. During a review of Resident 6's undated Care Plan titled, Diabetes Mellitus, the care plan indicated to give diabetes medications and check fasting serum BS as ordered by doctor. c) During a review of Resident 7's Face Sheet, dated 5/10/21, the face sheet indicated Resident 7 was admitted to the facility on [DATE] with diagnosis including diabetes. During a review of Resident 7's Order Summary Report, dated 5/10/21, the report indicated on 3/18/21 Resident 7 was prescribed Glargine 5 units subcutaneously one time a day, to hold if BS less than 100, and Insulin Regular as per sliding scale subcutaneously three times a day AC meals and HS. During a review of Resident 7's BGM dated 4/1/21 to 5/10/21, the BGM indicated a total of 11 BS levels not documented, 3 doses of Glargine and 8 doses of Insulin Regular sliding scale were not signed as administered to Resident 7. During a review of Resident 7's Care Plan titled, Diabetes Mellitus, dated 1/21/21, the care plan indicated to give diabetic medications as ordered by the doctor. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 35's Order Summary Report, dated 5/10/21, the report indicated on 10/28/20 Resident 35 was prescribed Insulin Regular as per sliding scale subcutaneously two times a day AC (before) breakfast and HS (bedtime), on 3/14/20 Levemir 10 units subcutaneously one time a day and to hold if BS less than 100, and on 2/27/21 Levemir (type of insulin) 10 units subcutaneously at HS and to hold if BS less than 100. During a review of Resident 35's BGM between 4/1/21 and 5/10/21, the BGM indicated a total of 15 BS levels not documented, 9 doses of Levemir and 6 doses of Insulin Regular sliding scale not signed as administered to Resident 35. During a review of Resident 35's Care Plan, titled, Diabetes Mellitus, dated 3/7/20, the care plan indicated to give diabetes medications as ordered by doctor. k) During a review of Resident 36's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 36 was admitted to the facility on [DATE] with a diagnosis of diabetes. During a review of Resident 36's Order Summary Report, dated 5/10/21, the report indicated on 3/9/21 Resident 36 was prescribed Insulin Regular as per sliding scale. During a review of Resident 36's MAR starting 4/1/21 thru 5/10/21, the MAR indicated 13 doses were not given and BS not checked. l) Review of Resident 41's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 41 was admitted to the facility on [DATE] with diagnoses including diabetes. During a review of Resident 41's Order Summary Report, dated 5/10/21, the report indicated on 9/14/20 Resident 41 was prescribed Glargine 5 unit subcutaneously two times a day and to hold if BS less than 100. During a review of Resident 41's BGM starting 9/1/20 thru 5/10/21, the BGM indicated a total of 60 BS levels not documented, and 60 Glargine doses not signed as administered to Resident 41. During a review of Resident 41's care plan titled, Diabetes Mellitus, dated 1/2/21, the care plan indicated to monitor BS by finger stick, administer oral medication and/or insulin and notify the physician of significant changes. m) Review of Resident 47's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 47 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes. During a review of Resident 47's Order Summary Report, dated 5/10/21, the report indicated on 3/2/21 Resident 47 was prescribed insulin regular per sliding scale. During a review of Resident 47's BGM starting 4/1/21 thru 5/10/21, the BGM indicated a total of 20 BS levels not documented and not signed as administered to Resident 47. During a review of Resident 47's undated care plan titled, Diabetes Mellitus, the care plan indicated to monitor BS by finger stick, administer oral medication and/or insulin and notify the physician of significant changes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 322's Order Summary Report, dated 5/10/21, the report indicated on 5/5/21 Resident 322 was prescribed insulin Humalog per sliding scale, on 4/30/30 Levemir 28 units one time a day and Levemir 30 units at bedtime. During a review of Resident 322's BGM starting 4/29/21 thru 5/10/21, the BGM indicated a total of 20 BS levels and 15 insulin doses not documented and not signed as administered to Resident 322. During a review of Resident 322's care plans indicated no care plan for diabetes monitoring was created. During a review of Resident 41's clinical chart did not contain a record for HgA1c level physician order or lab results since admission. During a concurrent interview and review of resident's laboratory results, physician orders and care plans on 5/11/21 at 4:00 p.m., there were no HgA1C laboratory results noted in the chart for Residents 2, 7, 10, 11, 25, 26, 32, 35, 36, 41, 47, 52, 54, 57, 172, 173 and 322. The MDS coordinator stated after a thorough search for Residents 2, 7, 10, 11, 25, 26, 32, 35, 36, 41, 47, 52, 54, 57, 172, 173 and 322 HgA1c levels, physician orders and care plans to monitor HgA1C, she could not find the labs. During an interview on 5/11/21 at 9:36 a.m., Licensed Vocational Nurse 6 (LVN 6) stated insulin medication information was documented on the MAR, under Blood Sugar (BS). LVN 6 stated prior to the administration of medication, the staff would verify and check physician orders and compare them with the electronic records (eMAR). LVN 6 stated if the staff did not check the BS tab, they would not know to do the BS level checks. LVN 6 stated if registry staff was not familiar with the eMAR, they could overlook the BS tab and not administer the insulin. LVN 6 stated that nursing staff should provide a reason for missed doses of insulin or BS on the eMAR. LVN 6 stated if BS were not checked, then residents can go into diabetic coma because of BS being high. LVN 6 stated when a resident refuses a BS check or insulin dose, licensed nursing staff should make more attempts, make the physician aware, monitor the resident and document on the eMAR and progress notes. During an interview on 5/11/21 at 10:33 a.m., CP stated she completes Medication Regimen Review ([MRR] -a thorough evaluation of the medication regimen of a resident) for all residents. The CP stated for residents with diabetes she makes sure there are HgA1c level orders, and if not then she makes recommendations to the physician to order the level. The CP stated HgA1c levels should be ordered every three months and when residents are stable then it can be done every six months. The CP stated ordering HgA1c levels every three months was standard of practice, and a diagnostic tool to evaluate the effectiveness of therapy for the resident to determine if changes in medication therapy are necessary. The CP stated HgA1c levels above 8% should be evaluated closely and routinely. The CP stated she had noticed the facility had MAR charting gaps for the BS levels and insulin administration and had addressed this failure with the past DON. The CP stated the MRR for the month of March 2021 addresses this failure in the summary section to the previous DON. The CP stated she may have also communicated this failure to the new DON 1, whom she had only met once. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/11/21 at 11:02 a.m., the MDS Coordinator stated HgA1c should be monitored in the residents' Care Plan (document outlining a detailed approach to care customized to an individual resident's need.) The MDS stated that medical records department had not been tracking to ensure residents have HgA1c orders but will do so going forward. The MDS stated diabetic (persons with diabetes) residents on insulin should have HgA1c levels checked every three months. The MDS stated that HgA1c is important because it shows if the insulin therapy is effective for the resident and if any changes to the medications need to be made based on the level. The MDS stated that it is important to have the right medications for diabetic residents to make sure their BS levels are stabilized so that they do not have complications like coma, get hospitalized or die. The MDS stated all diabetic residents should have a baseline HgA1c when admitted and that lab services did not stop working even during COVID. During an interview on n 5/11/21 at 11:51 a.m., the DON 2 stated carrying out the orders given by physicians are important, especially for diabetic residents. The DON 2 stated documentation is basic nursing function. The DON 2 stated if the MAR had gaps and was not signed, then it was understood the BS orders were not carried out, and the insulin doses were not administered. The DON 2 stated HgA1c should be ordered at admission for diabetic residents and re-ordered every three months to know if the medications are working. The DON 2 stated that the diabetes care plan should include the monitoring for HgA1c. The DON 2 stated if BS levels were not checked and insulin doses not given then the residents could have low or high BS levels, go into coma, get hospitalized , have ketoacidosis (serious diabetes complication where the body produces excess blood acids), and even die. During a phone interview on 5/11/21 at 12:40 p.m., during a phone interview, the Medical Doctor (MD) 1 stated she usually orders HgA1c levels and when she overlooks to order the level, she gets reminded by the CP. The MD1 stated HgA1c should be ordered every three months and for stable residents can be every six months or yearly. The MD1 stated that BS levels are not enough to determine effectiveness of the medications and HgA1c level is needed to determine if changes in the medications are needed. The MD1 stated that not having HgA1c levels for residents is a concern and should be part of their diabetes care plan. The MD1 stated it is harmful for the resident when the BS level is not checked, or insulin orders not administered. During a review of the facility's policy and procedures (P/P) titled, Diabetes-Clinical Protocol, revised 2020, the P/P indicated for residents who meet the criteria for diabetes testing, the physician would order pertinent screening such as A1C. the P/P indicated the staff would monitor blood glucose levels as indicated by the physician. During a review of the facility's P/P titled, Insulin Administration, revised on 9/2014, the facility staff would document the blood glucose results as ordered by the physician and document the dose and concentration of the insulin injection. During a review of the facility's P/P titled, Obtaining a Fingerstick Glucose Level, revised 9/2011, the P/P indicated the staff would document the name of the staff performing the fingerstick, date and time performed, assessment and data obtained during the procedure, refusal and reasons for refusal and interventions taken, blood sugar results and physician notification and signature of the staff.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36394 Based on observation, interview and record review the facility failed to ensure a resident's call light was withing reach and promptly attempt to her needs for one of one sampled resident (Resident 59). This deficient practice resulted in Resident 59 falling and hitting her head on the side table and the base of the bed resulting in pain and bruising. Findings: During a review of Resident 59's Admission Record (Face Sheet) indicated the resident was initially admitted to the facility on [DATE]. Resident 59 diagnoses included Chronic Kidney disease (inability of the kidney to function) and Hyperkalemia (high potassium levels). During a review of Resident 59's Minimum Data Set (MDS), an assessment and care-screening tool, dated 4/16/2021, the MDS indicated Resident 59 was able to make herself understood and understood others and was moderately impaired of cognition skills (thought process). The MDS indicated Resident 59 was totally depended on staff for activities of daily living (ADLs). During a review of Resident 59's Fall Risk Data Collection (FRD), dated 11/9/16, the FRD indicated a score of 14 (score of 10 or above represents high risk for falls). The FRD indicated Resident 59 required assist in mobility with bowel and bladder eliminations. During a review of Resident 59's care plan titled, Fall Risk Prevention, dated 10/19/17, the care plan indicated the facility will provide a safe environment, free of any clutters, kept call light within reach and answer promptly. During a review of Resident 59's Nursing Progress Notes (NPN), dated 5/3/2021 at 11:25 p.m., the NPN indicated Resident 59 was found on the floor next to her bed on her right side in a fetal position with her head resting on the base of the bedside table. The NPN indicated no injuries noted. The NPN indicated the facility staff did not complete the 72 hours neurological assessment charting post fall as indicated in the facility's policy. During an observation and interview on 05/06/21 at 11:50 a.m., in the presence and translation of Licensed Vocational Nurse 5 (LVN 5), Resident 59 stated she fell on [DATE] while trying to reach for the call light when suddenly she lid off the mattress hitting her head on the base of the bedside table while her legs were hanging. Resident 59 stated she had pain in her head and all over her body. Resident 59 was observed with discolorations to bilateral lower arms which according to the resident, the discolorations were sustained by the staff rough handling her while picking her up from the floor. LVN 5 confirmed the call light was placed on the bed side lamp table further away from Resident 59's reach. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/06/21, at 1:31 p.m., Director of Staff Development (DSD) stated she was informed by LVN 6 Resident 59 was found on the floor on her side without any injury on 5/3/2021 at 11 p.m. During an interview on 5/06/21, at 4:01 p.m., LVN 6 stated on 5/3/21 at 11: 10 p.m., she heard Resident 59 calling out for help. LVN 6 stated upon entering the room, Resident 59 was on the floor in a fetal position with her head resting on the base of the bed side table. LVN 6 stated Resident 59 denied any pain at that time. LVN 6 stated there was no 72 hours charting or assessment initiated, or x ray (image of a body part) order obtained. During a review of the facility's policy and procedures (P/P) titled, Falls and Falls Risk Managing, revised 2018, the P/P indicated the staff would monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. (how about assessment post fall and physician notification).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43455 Based on observation, interview, and record review the facility failed to implement its policy and procedures (P/P), Controlled Medication Disposal, and include the verifying signatures of either the Director of Nursing (DON) or a Registered Nurse (RN) along with the Consultant Pharmacist ([CP] specialist trained to assist with long-term care residents with special medications needs and educate both residents and healthcare providers) on the Antibiotic or Controlled Drug Record (Controlled Substance [CS]- medications that have the potential for abuse and dependency) logs for the final disposition (process of returning and/or destroying unused medications) of the CS for 3/2021 and 4/2021. This deficient practice had the potential for CS diversion (transfer of a controlled substance or other medication from a lawful to an unlawful channel of distribution or use) and risk for residents and staff in the facility to accidentally be exposed to harmful medications than can lead to physical harm and hospitalization . Findings: During a concurrent interview and review of the CS logs for 3/2021 through 4/2021, on 5/6/21 at 1:38 p.m., the CS logs were inconsistent some having only one staff signature and other days no signatures noted. DON 1 stated the final CS disposition process was conducted by her and any available Licensed Vocational Nurse (LVN) or RN. The DON 1 stated she and the Licensed Nurse disposing a CS would sign the CS log to verify count. DON 1 stated, she then would lock the CS in a cabinet located in her office and wait for final disposition. The DON 1 stated only she had access to the locked cabinet, and once a month, or as needed, she would dispose of the CS's in a white and blue pharmaceutical waste bucket (containers for disposing medications) with an RN or with the CP. The DON 1 stated the disposed medications in the bucket were for the CS from the month of April 2021. The DON 1 stated she was unable to locate the CP signature log for the CS logs for 3/2021 through 4/2021. The DON 1 stated the final CS disposition had to be done in the presence of an RN or DON and the CP logs signed by them upon the disposition of the CS. The DON 1 acknowledged the understanding of accountability involved with CS's, and stated she understood the potential for diversion of CS's, safety, and accidental exposure to harmful medications for the residents and staff. The DON 1 stated she failed to follow the facility policy to dispose of the CS's and sign the Antibiotic or Controlled Drug Record (CS) logs in the presence of the CP. During an interview on 5/7/2021 at 9:40 a.m., the Administrator (ADM) stated the final CS disposition should be done with an RN or DON and the CP and should not be done with only an LVN or RN. The ADMIN stated the facility failed to dispose of the CS according to policy with the DON and CP. During an interview on 5/11/2021 at 11:51 a.m., the DON 2 stated upon the discharge of a resident or discontinuation of a resident's CS, the CS was surrendered to the DON. The DON 2 stated at the time of surrendering of the CS, the licensed nursing staff and the DON would account for all the remaining doses and sign the CS log. The DON 2 stated once a month or as needed, the final CS disposition was done with the DON and CP and both would sign the CS log. The DON 2 stated CS should have been supervised disposition to avoid diversion, have accountability and prevent accidental exposure of harmful medications to residents and staff. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's P/P titled, Controlled Medication Disposal, dated 4/2008, the P/P indicated medications included in the Drug Enforcement Administration (DEA) classification as controlled substances were subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations. The P/P indicated the DON and the CP were responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Also, schedule II-V controlled substances remining in the facility after a resident had been discharged , or the order discontinued, were disposed of in the facility by the DON or designated facility RN in conjunction with the CP.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39028 Based on interviews, record review, facility failed to follow up with consultant Pharmacist monthly Medication regimen review (MRR) and the recommendations for the prescribing physician towards resident's care on two of four sampled residents (Residents 42 and 60) This deficient practice resulted in Residents 42 and 60, who were on anticoagulant (chemical substances that prevent or reduce coagulation of blood, prolonging the clotting time) medications, not having laboratory works done every two weeks as ordered by the physician to ensure the residents were receiving their therapeutic dose. Findings: During a review of Resident 42's Admission (Face Sheet) indicated the resident was originally admitted to the facility on [DATE]. Resident 42's diagnoses included laceration of unspecified part of colon (longest part of the large intestine [a tube-like organ connected to the small intestine at one end and the anus at the other]), muscle weakness (generalized), other abnormalities of gait and mobility, and hypotension (low blood pressure). During a review of Resident 42's Minimum Data Set (MDS), an assessment and care-screening tool, dated 3/21, the MDS indicated Resident 42 had intact cognitive (had full capacity to understand or to be understood by others) in thought process. During a review of Resident 42's physician's order, dated 3/3/21, indicated Aspirin (anticoagulant and fever reducer) tablet delayed release 81 milligrams ([mg] units of measurement), give one (1) tablet by mouth one time a day. During a review of Resident 42's physician order, dated 3/3/21, indicated Lovenox (anticoagulant) 30 mg/0.3ml, inject 30mg subcutaneous. During a review of Resident 42's care plan, dated 3/3/21, the care plan indicated no care plan was crated for the use of the anticoagulant Aspirin 81 mg by mouth once a day. During a review of Resident 42's care plan, dated 3/3/21, for Lovenox therapy for Deep Vein Thrombosis ([DVT] blood clot in a deep vein, usually in the legs) indicated lab works as ordered, monitor, document and report to primary physician any changes. During a review of Resident 42's MRR, the facility pharmacist recommended Resident 42 to have lab work monitored every two weeks while the resident is on Lovenox. The record of Resident 42's labs did not indicate it was done or monitored. During a review of Resident 42's laboratory work starting 3/3/21, there was no laboratory work found in the clinical chart. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 60's Face Sheet indicated the resident was admitted to the facility on [DATE]. Resident 60's diagnoses included acquired absence of right leg below knee, muscle weakness, gangrene (dead of body tissue). During a review of Resident 60's MDS, dated [DATE], the MDS indicated Resident 60 had impaired cognitive in thought process. During a review of Resident 60's care plans, dated 5/5/21, the care plans did not indicate Resident 60's use of two types of antiplatelet (medication that works by preventing platelets [clopidogrel and Apixaban]) at the same time. During a concurrent interview and review of the MRR, on 5/11/21 at 11:59 a.m., LVN 1 stated the consultant pharmacist came to the facility at the beginning of each month to review every resident's medication, and the Registered Nurse (RN) was supposed to follow up with any recommendations and notify the physicians of any recommendation by the Consultant pharmacy (CP), if the physician agreed with the recommendation, the staff followed up with it. LVN 1 stated there was no follow-up with the CP recommendations for Residents 42 and 60. During an interview on 5/11/21 at 12:25 p.m., the Case manager (CM) stated CP's recommendations were given to the Director of Nursing (DON), and RN for follow up. CM confirmed there was no follow up with the CP's recommendations for Residents 42 and 60 done with the primary physicians. During a review of facility's Policy and Procedure(P/P), titled Medication Regimen Reviews, dated 5/2019, the P/P indicated the CP performed a medication regimen review (MRR) for every resident in the facility receiving medication to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication such as duplicative therapies or omissions of ordered medications. The P/P indicated if the physician did not provide a timely response, or the consultant Pharmacist identified no action had been taken, it was the duty of the pharmacist to contact the Medical Director, and the Administrator. 43455

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview, and record review, the facility failed to administer insulin (medication used to treat and regulate high blood sugar [BS] levels) doses and document on the Medication Administration Record (MAR) for 21 of 21 sampled residents (Residents 2, 6, 7, 10, 11, 25, 26, 32, 33, 35, 36, 41, 47, 52, 54, 57, 60, 61, 172, 173 and 322) through the period starting 4/1/2021 thru 5/10/2021 as followed: 1) Resident 2 did not received seven (7) doses of Lantus insulin (long-acting medication used to control elevated Blood Sugar [BS]) 20 units ([U] units of measurement), and 18 doses of Humulin R (type of insulin) subcutaneously (under the skin) as per sliding scale (insulin dose dependent on the BS level). 2) Resident 6 did not receive 12 doses of Levemir (long-acting insulin) 15 units subcutaneously, and 15 doses of Novolin R (short-acting insulin) as per sliding scale subcutaneously. 3) Resident 7 did not receive three (3) doses of Glargine (long-acting insulin used to control BS) 5 units subcutaneously, and eight (8) doses of Insulin Regular (type of insulin) as per sliding scale subcutaneously. 4) Resident 10 did not receive eight (8) doses of Basaglar Kwikpen (long-acting insulin) 20 units, and 14 doses of Insulin Regular as per sliding scale subcutaneously. 5) Resident 11 did not receive six (6) doses of Basaglar Kwikpen 20 units subcutaneously, one (1) dose of Lantus 20 units subcutaneously, and 10 doses of Insulin Regular as per sliding scale subcutaneously. 6) Resident 25 did not receive seven (7) doses of Humulin R (immediate-acting insulin used to help with elevated BS) as per sliding scale subcutaneously. 7) Resident 26 did not receive nine (9) doses of Lispro (fast-acting insulin) as per sliding scale subcutaneously. 8) Resident 32 did not receive 19 doses of Insulin Regular as per sliding scale subcutaneously. 9) Resident 33 did not receive 14 doses of Regular Insulin as per sliding scale subcutaneously. 10) Resident 35 did not receive nine (9) doses of Levemir 10 units, and six (6) doses of Insulin Regular as per sliding scale subcutaneously. 11) Resident 36 did not receive 13 doses of Insulin Regular as per sliding scale subcutaneously. 12) Resident 41 did not receive 60 doses of Glargine five (5) units subcutaneously between 9/14/20 through 5/10/21. 13) Resident 47 did not receive 20 doses of Insulin Regular as per sliding scale subcutaneously. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	14) Resident 52 did not receive 18 doses of Insulin Regular as per sliding scale subcutaneously. 15) Resident 54 did not receive five (5) doses of Novolin R as per sliding scale subcutaneously. 16) Resident 57 did not receive seven (7) doses of Glargine 15 units subcutaneously. 17) Resident 60 did not receive six (6) doses of Detemir (type of insulin) 15 units subcutaneously, and eight (8) doses of Insulin Regular as per sliding scale subcutaneously. 18) Resident 61 did not receive 12 doses of Humulin N Kwikpen (type of insulin) 20 units subcutaneously, and 17 doses of Insulin Regular as per sliding scale subcutaneously. 19) Resident 172 did not receive four (4) doses of Glargine 30 units subcutaneously. 20) Resident 173 did not receive eight (8) doses of Humulin R as per sliding scale subcutaneously. 21) Resident 322 did not receive five (5) doses of Levemir 28 units subcutaneously, two (2) doses of Levemir 30 units subcutaneously, and 13 doses of Humalog (type of insulin) as per sliding scale subcutaneously. This deficient practice of failing to administer insulin doses in accordance with physician's orders resulted in Residents 2, 6, 7, 10, 11, 25, 26, 32, 33, 35, 36, 41, 47, 52, 54, 57, 60, 61, 172, 173 and 322 not receiving their therapeutic insulin doses as ordered by the physician and had the potential to compromise the resident's health and increased the risk to experienced serious health complications such hyperglycemia (excess of sugar in the blood), coma (a prolonged period of unconsciousness brought on by illness or injury) and likely resulting in hospitalization or death. On 5/10/2021 at 4:09 p.m., the Administrator (ADMIN) and the Director of Nursing 1 (DON 1), were notified an Immediate Jeopardy ([IJ], a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called for the facility's failure to have a system in place for 21 of 21 residents from receiving scheduled and as needed (sliding scale) medications as prescribed by the physician. The facility's ADMIN and DON 1 were notified of the potential for serious harm to all 21 residents and seriousness of the residents' health and safety being threatened. On 5/11/2021 at 3:25 p.m., the ADMIN was notified the IJ was lifted after review and on-site validation of the accepted Plan of Action (POA) via observations, interviews, and record review of the following: 1. On 5/10/21, Quality Assurance in-serviced all licensed nurses including registry nurses, regarding insulin administration using the facility's Point Click Care (PCC) to ensure that no insulin order has been omitted and performed accordance with physicians' orders and BS check on PCC as ordered. 2. All identified and affected residents were assessed by RN Supervisor on 5/10/21. No acute change in condition noted. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. On 5/10/21, all residents with diabetes records were reviewed to ensure HgA1c test result were available. Nine residents were identified to not have HgA1c test since admission, and six residents with HgA1c ([hemoglobin A1c] test that evaluates the average amount of glucose in the blood over three [3] months by measuring the percentage glycated hemoglobin in the blood) test more than three months old. 4. On 5/10/21, licensed nurses contacted the physicians for those residents and obtained orders to perform HgA1c test. Lab test performed, processed, and result received as of 5/11/21. Seven resulted HgA1c reviewed, and physician notified of recent results. Physicians response and orders will be carried out and resident/Responsible Party (RP) notified for any changes. 5. Affected residents will be monitored for 72 hours for any changes in condition. Care Plan reviewed and interventions updated 5/11/21 and ongoing. 6. On 5/11/21, medical records department conducting audit for all residents with MD order for HgA1c and ongoing. 7. Ongoing licensed nurses including registry nurses in-service being conducted by the DON 2 and Director of Staff Development (DSD) on 5/11/21 on the following topic: review of Policy and Procedure on Diabetes Clinical Protocol, Insulin Administration and Medication Administration documentation, including but not limited to laboratory test order follow up with physician and RP notification. Completion date 5/14/21. 8. Medication Administration Record (MAR) will be audited by the medical records designee daily Monday to Friday to ensure that BS check and insulin administration recorded timely. The Registered Nurse (RN) Supervisor/Designee will check the PCC eMAR (electronic MAR) dashboard daily to ensure compliance. 9. Licensed nurses will check and monitor PCC eMAR during their shift to ensure complete and timely documentation. 10. The medical records department will maintain daily audit of laboratory results, for example, HgA1c Monday to Friday. Findings will be discussed during the daily morning meeting for further follow up and management. 11. The Consulting Pharmacist (Consulting Pharmacist) will maintain the monthly Medication Regimen Review (MRR) with emphases on assessing residents with Insulin order and on diabetic management. Follow up with physician, resident and RP notification for any treatment changes will be carried out by the licensed nurses. 12. Applicable Policy and Procedures reviewed on 05/11/2021, no changes made at this time. 13. The CP will monitor compliance with physicians' orders monthly and present a report to the DON2 and ADMIN. 14. The DON2 or designee will provide a summary trend analysis of findings to the monthly Quality Assurance and Performance Improvement ([QAPI] committee meeting for review and recommendations). If there are no negative findings reported after six months, issue is considered resolved. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Findings: a) During a review of Resident 2's Admission Record (Face Sheet), dated 5/10/21, the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE] with a diagnosis of diabetes (a condition characterized by high levels of BS which can lead to serious damage to the heart, eyes and kidneys [pair of organs responsible for filtering waste materials out of the blood and passing them out of the body as urine, and regulating blood pressure of the body]). During a review of Resident 2's Medication Administration Record (MAR), for the review periods of 4/2021 through 5/2021, the MAR indicated Resident 2 was prescribed Lantus 20 units in the morning, hold if BS less than 100, subcutaneously before meals and at bedtime and per sliding scale. Resident 2's MAR indicated that a total of 21 BS levels were not documented, seven (7) doses of Lantus were not signed as administered, and 18 doses of Humulin R as per sliding scale were not signed as administered to Resident 2. During a review of Resident 2's undated Care Plan titled, Diabetes Mellitus, dated 3/21/2021, the care plan indicated to give diabetic medications as ordered by the physician, and check fasting serum (blood) BS. b) During a review of Resident 6's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 6 was admitted to the facility on [DATE] with a diagnosis of diabetes. During a review of Resident 6's Order Summary Report, dated 5/10/21, the report indicated Resident 6 was prescribed Novolin R as per sliding scale subcutaneously before meals and at bedtime and Levemir 15 units subcutaneously two times a day and to hold for BS less than 100. During a review of Resident 6's Blood Glucose Monitoring ([BGM] - where the insulin doses and BS are documented) log between 4/1/21 and 5/10/21 indicated a total of 27 BS levels not documented, 12 doses of Levemir were not signed as administered, and 15 doses of Novolin R as per sliding scale were not signed as administered. During a review of Resident 6's undated Care Plan titled, Diabetes Mellitus, the care plan indicated to give diabetes medications and check fasting serum BS as ordered by doctor. c) During a review of Resident 7's Face Sheet, dated 5/10/21, the face sheet indicated Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Order Summary Report, dated 5/10/21, the report indicated on 3/18/21 Resident 7 was prescribed Glargine 5 units subcutaneously one time a day, to hold if BS less than 100, and Insulin Regular as per sliding scale subcutaneously three times a day AC meals and HS. During a review of Resident 7's BGM dated 4/1/21 to 5/10/21, the BGM indicated a total of 11 BS levels not documented, 3 doses of Glargine and 8 doses of Insulin Regular sliding scale were not signed as administered to Resident 7. During a review of Resident 7's Care Plan titled, Diabetes Mellitus, dated 1/21/21, the care plan indicated to give diabetic medications as ordered by the doctor. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 7's clinical chart, the physician orders dated 5/10/21 indicated HgA1c level was ordered by the physician on admission. d) During a review of Resident 10's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 10 was admitted to the facility on [DATE] with a diagnosis of diabetes. During a review of Resident 10's Order Summary Report, dated 5/10/21, the report indicated on 11/23/20 Resident 10 was prescribed Insulin Regular as per sliding scale subcutaneously before meals and at bedtime and on 1/10/21 Basaglar Kwikpen 20 units in the morning and to hold for BS less than 100 was prescribed. During a review of Resident 10's BGM starting 4/1/21 thru 5/10/21, the BGM indicated a total of 22 BS levels not documented, 8 doses of Basaglar Kwikpen were not signed as administered, and 14 doses of Insulin Regular as per sliding scale were not signed as administered to Resident 10. During a review of Resident 10's Care Plan titled, Diabetes Mellitus, dated 10/24/20, the care plan indicated to give diabetic medications as ordered by the doctor. e) During a review of Resident 11's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 11 was initially admitted to the facility on [DATE] with a diagnosis of diabetes. During a review of Resident 11's Order Summary Report, dated 5/10/21, the report indicated on 12/12/20 Resident 11 was prescribed Basaglar Kwikpen 20 units subcutaneously two times a day, Lantus 20 units subcutaneously two times a day, and insulin Regular as per sliding scale subcutaneously before meals and at bedtime. During a review of Resident 11's BGM starting 4/1/21 thru 5/10/21, the BGM indicated a total of 17 BS levels not documented, 1 dose of Lantus was not signed as administered, 6 doses of Basaglar not signed as administered, and 10 doses of Insulin Regular as per sliding scale were not signed as administered to Resident 11. During a review of Resident 11's Care Plan titled, Diabetes Mellitus, dated 10/10/20, the care plan indicated to give diabetes medications as ordered by the doctor and check fasting serum BS as ordered by the doctor. f) During a review of Resident 25's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 25 was admitted to the facility on [DATE] with a diagnosis of diabetes. During a review of Resident 25's Order Summary Report, dated 5/10/21, the report indicated on 3/2/21 Resident 25 was prescribed Humulin R as per sliding scale subcutaneously three times a day. During a review of Resident 25's BGM starting 4/1/21 thru 5/10/21, the BGM indicated a total of 7 BS levels not documented, and 7 doses of Humulin R as per sliding scale not signed as administered to Resident 25. During a review of Resident 25's Care Plan titled, Diabetes Mellitus, dated 11/20/20, the care plan indicated to give diabetes medications as ordered by doctor and check fasting serum BS. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	g) During a review of Resident 26's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 26 was admitted to the facility on [DATE] with a diagnosis of diabetes. During a review of Resident 26's Order Summary Report, dated 5/10/21, the report indicated on 4/7/21 Resident 26 was prescribed Lispro as per sliding scale subcutaneously before meals and at bedtime. During a review of Resident 26's BGM starting 4/1/21 thru 5/10/21, the BGM indicated a total of 9 BS levels not documented, and 9 doses of Lispro sliding scale not signed as administered to Resident 26. During a review of Resident 26's Care Plan titled, Diabetes Mellitus, dated 4/7/21, the care plan indicated to give diabetes medications as ordered by the doctor and check fasting serum BS. h) During a review of Resident 32's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 32 was admitted to the facility on [DATE] with a diagnosis of diabetes. During a review of Resident 32's Order Summary Report, dated 5/10/21, the report indicated on 1/10/21 Resident 32 was prescribed Insulin Regular as per sliding scale subcutaneously before meals and at bedtime. During a review of Resident 32's BGM starting 4/1/21 thru 5/10/21, the BGM indicated a total of 19 BS levels were not documented, and 19 doses of Insulin Regular as per sliding scale not signed as administered to Resident 32. During a review of Resident 32's undated Care Plan titled, Diabetes Mellitus, the care plan indicated to monitor BS by finger stick, administer insulin, give diabetes medications, and check fasting serum BS as ordered by the doctor. i) During a review of Resident 33's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 33 was admitted to the facility on [DATE] with a diagnosis of diabetes. During a review of Resident 33's Order Summary Report, dated 5/10/21, the report indicated on 3/2/21 Resident 33 was prescribed Insulin Regular as per sliding scale subcutaneously before meals and at bedtime. During a review of Resident 33's BGM between 4/1/21 and 5/10/21, the BGM indicated a total of 14 BS levels not documented, and 14 doses of Insulin Regular as per sliding scale not signed as administered to Resident 33. During a review of Resident 33's Care Plan titled, Diabetes Mellitus, dated 12/28/20, the care plan indicated to give diabetes medications and check fasting serum BS as ordered by the doctor. j) During a review of Resident 35's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including diabetes. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 35's Order Summary Report, dated 5/10/21, the report indicated on 10/28/20 Resident 35 was prescribed Insulin Regular as per sliding scale subcutaneously two times a day AC (before) breakfast and HS (bedtime), on 3/14/20 Levemir 10 units subcutaneously one time a day and to hold if BS less than 100, and on 2/27/21 Levemir (type of insulin) 10 units subcutaneously at HS and to hold if BS less than 100. During a review of Resident 35's BGM between 4/1/21 and 5/10/21, the BGM indicated a total of 15 BS levels not documented, 9 doses of Levemir and 6 doses of Insulin Regular sliding scale not signed as administered to Resident 35. During a review of Resident 35's Care Plan, titled, Diabetes Mellitus, dated 3/7/20, the care plan indicated to give diabetes medications as ordered by doctor. k) During a review of Resident 36's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 36 was admitted to the facility on [DATE] with a diagnosis of diabetes. During a review of Resident 36's Order Summary Report, dated 5/10/21, the report indicated on 3/9/21 Resident 36 was prescribed Insulin Regular as per sliding scale. During a review of Resident 36's MAR starting 4/1/21 thru 5/10/21, the MAR indicated 13 doses were not given and BS not checked. l) Review of Resident 41's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 41 was admitted to the facility on [DATE] with diagnoses including diabetes. During a review of Resident 41's Order Summary Report, dated 5/10/21, the report indicated on 9/14/20 Resident 41 was prescribed Glargine 5 unit subcutaneously two times a day and to hold if BS less than 100. During a review of Resident 41's BGM starting 9/1/20 thru 5/10/21, the BGM indicated a total of 60 BS levels not documented, and 60 Glargine doses not signed as administered to Resident 41. During a review of Resident 41's care plan titled, Diabetes Mellitus, dated 1/2/21, the care plan indicated to monitor BS by finger stick, administer oral medication and/or insulin and notify the physician of significant changes. m) Review of Resident 47's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 47 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes. During a review of Resident 47's Order Summary Report, dated 5/10/21, the report indicated on 3/2/21 Resident 47 was prescribed insulin regular per sliding scale. During a review of Resident 47's BGM starting 4/1/21 thru 5/10/21, the BGM indicated a total of 20 BS levels not documented and not signed as administered to Resident 47. During a review of Resident 47's undated care plan titled, Diabetes Mellitus, the care plan indicated to monitor BS by finger stick, administer oral medication and/or insulin and notify the physician of significant changes. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	n) Review of Resident 52's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 57 was admitted to the facility on [DATE] with diagnoses including diabetes. During a review of Resident 52's Order Summary Report, dated 5/10/21, the report indicated on 1/10/21 Resident 52 was prescribed insulin regular per sliding scale. During a review of Resident 52's BGM starting 4/1/21 thru 5/10/21, the BGM indicated a total of 17 BS levels and insulin was not documented, signed as administered to Resident 52. During a review of Resident 52's care plan titled, Diabetes Mellitus, dated 2/21/21, the care plan indicated to monitor BS by finger stick, administer oral medication and/or insulin and notify the physician of significant changes. o) Review of Resident 54's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 54 was admitted to the facility on [DATE] with diagnoses including diabetes. During a review of Resident 54's Order Summary Report, dated 5/10/21, the report indicated on 4/29/21 Resident 54 was prescribed insulin regular per sliding scale. During a review of Resident 54's BGM starting 4/29/21 thru 5/10/21, the BGM indicated a total of five (5) BS levels not documented and not signed as administered to Resident 54. During a review of Resident 54's care plan titled, Diabetes Mellitus, dated 3/19/21, the care plan indicated to monitor BS by finger stick, administer oral medication and/or insulin and notify the physician of significant changes. p) Review of Resident 57's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 57 was admitted to the facility on [DATE] with diagnoses including diabetes. During a review of Resident 57's Order Summary Report, dated 5/10/21, the report indicated on 1/10/21 Resident 57 was prescribed insulin glargine 15 units subcutaneously two times a day. During a review of Resident 57's BGM starting 4/1/21 thru 5/10/21, the BGM indicated a total of nine (9) BS levels not documented, and insulin not signed as administered to Resident 57. During a review of Resident 57's care plan titled, Diabetes Mellitus, dated 7/7/20, the care plan indicated to monitor BS by finger stick, administer oral medication and/or insulin and notify the physician of significant changes. q) Review of Resident 60's Face Sheet, dated 4/11/21, the Face Sheet indicated Resident 60 was admitted to the facility on [DATE] with diagnoses including diabetes. During a review of Resident 60's Order Summary Report, dated 5/10/21, the report indicated on 4/13/21 Resident 60 was prescribed regular insulin detemir 15 units two times a day and Regular insulin per sliding scale. During a review of Resident 60's BGM starting 4/13/21 thru 5/10/21, the BGM indicated a total of 13 BS levels and insulin doses not documented and not signed as administered to Resident 60. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 60's care plan titled, Diabetes Mellitus, dated 4/12/21, the care plan indicated to monitor BS by finger stick, administer oral medication and/or insulin and notify the physician of significant changes. r) Review of Resident 61's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including diabetes. During a review of Resident 61's Order Summary Report, dated 5/10/21, the report indicated on 4/13/21 Resident 61 was prescribed insulin regular as per sliding scale and on 2/8/21 Humulin KiwiPen 20 units every morning and at bedtime was prescribed. During a review of Resident 61's BGM starting 4/1/21 thru 5/10/21, the BGM indicated a total of nine 30 BS levels and insulin doses not documented and not signed as administered to Resident 61. During a review of Resident 61's care plan titled, Diabetes Mellitus, dated 4/1/21, the care plan indicated to monitor BS by finger stick, administer oral medication and/or insulin and notify the physician of significant changes. s) Review of Resident 172's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 172 was admitted to the facility on [DATE] with diagnoses including diabetes. During a review of Resident 172's Order Summary Report, dated 5/10/21, the report indicated on 4/3/21 Resident 172 was prescribed insulin Glargine 30 units subcutaneous at bedtime. During a review of Resident 172's BGM starting 4/3/21 thru 5/10/21, the BGM indicated a total of 13 BS levels and insulin doses were not documented and signed as administered to Resident 172. During a review of Resident 172's care plan titled, Diabetes Mellitus, dated 4/22/21, the care plan indicated to monitor BS by finger stick, administer oral medication and/or insulin and notify the physician of significant changes. t) Review of Resident 173's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 173 was admitted to the facility on [DATE] with diagnoses including diabetes. During a review of Resident 173's Order Summary Report, dated 5/10/21, the report indicated on 4/22/21 Resident 173 was prescribed insulin regular as per sliding scale. During a review of Resident 173's BGM starting 4/22/21 thru 5/10/21, the BGM indicated a total of eight (8) BS levels and insulin doses not documented and not signed as administered to Resident 173. During a review of Resident 173's care plan titled, Diabetes Mellitus, dated 4/22/21, the care plan indicated to monitor BS by finger stick, administer oral medication and/or insulin and notify the physician of significant changes. u) Review of Resident 322's Face Sheet, dated 5/10/21, the Face Sheet indicated Resident 322 was admitted to the facility on [DATE] with diagnoses including diabetes. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 322's Order Summary Report, dated 5/10/21, the report indicated on 5/5/21 Resident 322 was prescribed insulin Humalog per sliding scale, on 4/30/30 Levemir 28 units one time a day and Levemir 30 units at bedtime. During a review of Resident 322's BGM starting 4/29/21 thru 5/10/21, the BGM indicated a total of 20 BS levels and 15 insulin doses not documented and not signed as administered to Resident 322. During a review of Resident 322's care plans indicated no care plan for diabetes monitoring was created. During an interview on 5/11/21 at 9:36 a.m., Licensed Vocational Nurse 6 (LVN 6) stated insulin medication information was documented on the MAR, under Blood Sugar (BS). LVN 6 stated prior to the administration of medication, the staff would verify and check physician orders and compare them with the electronic records (eMAR). LVN 6 stated if the staff did not check the BS tab, they would not know to do the BS level checks. LVN 6 stated if registry staff was not familiar with the eMAR, they could overlook the BS tab and not administer the insulin. LVN 6 stated that nursing staff should provide a reason for missed doses of insulin or BS on the eMAR. LVN 6 stated if BS were not checked, then residents can go into diabetic coma because of BS being high. LVN 6 stated when a resident refuses a BS check or insulin dose, licensed nursing staff should make more attempts, make the physician aware, monitor the resident and document on the eMAR and progress notes. During an interview on 5/11/21 at 10:33 a.m., CP stated she completes Medication Regimen Review ([MRR] -a thorough evaluation of the medication regimen of a resident) for all residents. The CP stated for residents with diabetes she makes sure there are HgA1c level orders, and if not then she makes recommendations to the physician to order the level. The CP stated HgA1c levels should be ordered every three months and when residents are stable then it can be done every six months. The CP stated ordering HgA1c levels every three months was standard of practice, and a diagnostic tool to evaluate the effectiveness of therapy for the resident to determine if changes in medication therapy are necessary. The CP stated HgA1c levels above 8% should be evaluated closely and routinely. The CP stated she had noticed the facility had MAR charting gaps for the BS levels and insulin administration and had addressed this failure with the past DON. The CP stated the MRR for the month of March 2021 addresses this failure in the summary section to the previous DON. The CP stated she may have also communicated this failure to the new DON 1, whom she had only met once. During an interview on 5/11/21 at 11:02 a.m., the MDS Coordinator stated HgA1c should be monitored in the residents' Care Plan (document outlining a detailed approach to care customized to an individual resident's need.) The MDS stated that medical records department had not been tracking to ensure residents have HgA1c orders but will do so going forward. The MDS stated diabetic (persons with diabetes) residents on insulin should have HgA1c levels checked every three months. The MDS stated that HgA1c is important because it shows if the insulin therapy is effective for the resident and if any changes to the medications need to be made based on the level. The MDS stated that it is important to have the right medications for diabetic residents to make sure their BS levels are stabilized so that they do not have complications like coma, get hospitalized or die. The MDS stated all diabetic residents should have a baseline HgA1c when admitted and that lab services did not stop working even during COVID. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on n 5/11/21 at 11:51 a.m., the DON 2 stated carrying out the orders given by physicians are important, especially for diabetic residents. The DON 2 stated documentation is basic nursing function. The DON 2 stated if the MAR had gaps and was not signed, then it was understood the BS orders were not carried out, and the insulin doses were not administered. The DON 2 stated HgA1c should be ordered at admission for diabetic residents and re-ordered every three months to know if the medications are working. The DON 2 stated that the diabetes care plan should include the monitoring for HgA1c. The DON 2 stated if BS levels were not checked and insulin doses not given then the residents could have low or high BS levels, go into coma, get hospitalized , have ketoacidosis (serious diabetes complication where the body produces excess blood acids), and even die. During a phone interview on 5/11/21 at 12:40 p.m., during a phone interview, the Medical Doctor (MD) 1 stated she usually orders HgA1c levels and when she overlooks to order the level, she gets reminded by the CP. The MD1 stated HgA1c should be ordered every three months and for stable residents can be every six months or yearly. The MD1 stated that BS levels are not enough to determine effectiveness of the medications and HgA1c level is needed to determine if changes in the medications are needed. The MD1 stated that not having HgA1c levels for residents is a concern and should be part of their diabetes care plan. The MD1 stated it is harmful for the resident when the BS level is not checked, or insulin orders not administered. During a review of the facility's policy and procedures (P/P) titled, Diabetes-Clinical Protocol, revised 2020, the P/P indicated for residents who meet the criteria for diabetes testing, the physician would order pertinent screening such as A1C. the P/P indicated the staff would monitor blood glucose levels as indicated by the physician. During a review of the facility's P/P titled, Insulin Administration, revised on 9/2014, the facility staff would document the blood glucose results as ordered by the physician and document the dose and concentration of the insulin injection. During a review of the facility's P/P titled, Obtaining a Fingerstick Glucose Level, revised 9/2011, the P/P indicated the staff would document the name of the staff performing the fingerstick, date and time performed, assessment and data obtained during the procedure, refusal and reasons for refusal and interventions taken, blood sugar results and physician notification and signature of the staff.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review the facility failed to: 1. Remove and discard from use one expired medication bubble pack (a medication package that holds individual medication pills in separate sealed compartments) for Resident 59, one insulin (a medication used to treat and regulate high blood sugar levels) vial (glass medication storage container) for Resident 41, one insulin pen (insulin injection device) for Resident 61, and one bronchodilator (medication used to prevent symptoms of Asthma [a condition that makes breathing difficult]) for Resident 52, from the medication cart, in one of two inspected medication carts (Medication Cart Station 3). 2. Label one insulin vial for Residents 61, with an open date in accordance with the manufacturer's requirements, in one of two inspected medication carts (Medication Cart Station 3). 3. Store one insulin pen for Resident 61, in the refrigerator, in accordance with the manufacturer's requirements in one of two inspected medication (Medication Cart Station 3). 4. Remove and discard from use one expired medication bubble pack for Resident 39, from the medication cart, in one of two inspected medication carts (Medication Cart Station 1). 5. Label one insulin pen for Residents 11, with an open date in accordance with the manufacturer's requirements, in one of two inspected medication carts (Medication Cart Station 1). 6. Store one insulin vial for Resident 10, in the refrigerator, in accordance with the manufacturer's requirements, in one of two inspected medication (Medication Cart Station 1). 7. Remove and discard from use three expired antibiotic (medication used to treat infections) intravenous (medication that is given through the veins) bags (type medication storage device) for Resident 51, and one expired antibiotic intravenous bag for Resident 172 from the refrigerator, in one of two inspected medication rooms (Medication room station 3). 8. Monitor the temperature of the second medication refrigerator, in one of two inspected medication rooms (Medication room station 3). 9. Remove and discard from use one expired emergency medication kit (storage container for emergency use medications) for facility stock from the medication room, and one expired vaccine vial for facility stock, one expired insulin vial for Resident 324, from the refrigerator, in one of two inspected medication rooms (Medication room yellow zone). These deficient practices increased the risk that Residents 10, 11, 39, 41, 51, 52, 59, 61, 172, and 324 could have received medication that had become ineffective or toxic due to improper storage or labeling, possibly leading to health complications resulting in hospitalization or death. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings: On 5/5/21 at 10:14 AM, during an observation of Medication Cart Station 3, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, expired and not discarded, or stored and labeled contrary to facility policies: 1. One open and expired Lantus (a brand name for a type of insulin) vial for Resident 41 was found stored at room temperature and labeled with an open date of 3/13/21. According to the manufacturer's product storage and labeling, opened Lantus insulin vials can be stored at room temperature below 86 degrees Fahrenheit or refrigerated between 36 to 46 degrees Fahrenheit and used or discarded within 28 days of opening vial. 2. One open and expired Humalog Kwikpen (a brand name for a type of insulin injection device) vial for Resident 61 was found stored at room temperature and labeled with an expiration date of 4/3/21. According to the manufacturer's product storage and labeling, opened Humalog Kwikpens can be stored at room temperature below 86 degrees Fahrenheit and discarded within 28 days of opening pen even if the pen still contains Humalog. 3. One open and expired Advair HFA (a brand name for a bronchodilator) oral inhaler (portable device for administering medication by breathing in) for Resident 52, was found stored at room temperature with the device medication dose counter reading 000. According to the manufacturer's product storage and labeling, opened Advair HFA inhalers can be stored at room temperature between 68 and 77 degrees Fahrenheit and should be discarded when the medication dose counter reads 000. 4. One Hydrocodone/APAP (combination opioid [narcotic] medication for treating pain) 5-325 (strength of medication) mg ([mg]-unit of measure of mass) tablet medication bubble pack for resident 59 was found stored at room temperature labeled with an expiration date of 3/21. According to manufacturer's specifications, facility policy, and pharmacy label, expired medications should not be used and discarded by the labeled expiration date. 5. One open Humulin R (a brand name for a type of insulin) vial for Resident 61 was found stored at room temperature and not labeled with a date on which use at room temperature began. According to the manufacturer's product storage and labeling, opened Humulin R insulin vials can be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 31 days of opening vial or once they've been stored at room temperature. 6. One unopened Humulin N Kwikpen (a brand name for a type of insulin injection) for Resident 61 was found stored at room temperature and not labeled with a date on which use at room temperature began. (continued on next page)

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	056415	A. Building B. Wing	05/11/2021

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the manufacturer's product storage and labeling, unopened Humulin N Kwikpens can be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 14 days when storage at room temperature began. On 5/5/21 at 11:11 AM, during an interview, Licensed Vocation Nurse (LVN)1 stated that the insulin vials and pens are not stored properly and not labeled with an open use date to know when they should be discarded and therefore considered expired. LVN1 stated the insulin vials are good for 28 days once opened. LVN1 stated these insulins should not be administered to residents since the insulins have lost their potency and the residents blood sugars will not be controlled. LVN1 stated the residents blood sugar can end up being high or low and cause them to go to the hospital and possibly have life threatening conditions like coma and eventually death when using expired insulin. LVN1 stated that the pain medication had expired end of March according to the pharmacy label on the bubble pack and using this medication would not be effective in treating the resident's pain. LVN1 stated that the resident would continue to have pain that can get worse, possibly causing psychosocial harm and inability to continue with normal daily activities. LVN1 stated when nurses come across unlabeled or expired medications, they should dispose of the medication. LVN1 stated that the Advair HFA medication dose counter reads 000, which means the device no longer contains medication. LVN1 stated if the resident does not receive this medication then the resident may have adverse breathing complications, asthma attacks and get hospitalized . On 5/6/21 at 11:56 AM, during an observation of the facility Station 3 medication room, the following was found: 1. Three unopened Vancomycin (an antibiotic) 750 mg intravenous (within a vein) bags (storage container for medication) for Resident 51 in the refrigerator labeled with an expiration date of 4/14/21, 4/30/21, and 4/30/21. According to manufacturer's specifications, facility policy, and pharmacy label, expired medications should not be used and discarded by the labeled expiration date. 2. One unopened Penicillin G (an antibiotic) 15 [NAME] ([million units] - unit of measure) intravenous bags for Resident 172 in the refrigerator labeled with an expiration date of 4/22/21. According to manufacturer's specifications, facility policy, and pharmacy label, expired medications should not be used and discarded by the labeled expiration date. 3. One refrigerator, stored with medications, without a temperature monitoring log. According to facility policy and manufacturer's specifications, medication requiring refrigeration need to be stored at specific refrigerator temperatures. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/6/21 at 12:13 PM, during an interview, Registered Nurse (RN)1 stated that antibiotic bags stored in the refrigerator are expired. RN1 stated the LVN's and the Consultant Pharmacist (CP) check for expired medications and dispose of them in the white and blue buckets (containers indicated for disposing medications). RN1 stated that giving expired antibiotics to residents will not help with their treatment because the antibiotic is not effective, and the residents can become septic (life threatening condition when the body's response to an infection damages its own tissues), go to the hospital or die. RN1 stated that the refrigerator temperature should be checked every morning and evening and documented on the refrigerator monitoring log. RN1 stated there is no refrigerator monitoring log on the second refrigerator. RN1 stated it is unknown what temperature the medications in the second refrigerator have been stored at. RN1 stated the temperature of both refrigerators should be monitored to ensure the medications are kept at certain temperature ranges according to the manufacturer guidelines and their facility policy. RN1 stated the medications in the second refrigerator will not be effective for the residents, and they should be considered expired and disposed of. On 5/6/21 at 1:06 PM, during an observation of the facility yellow zone medication room, the following was found: 1. One open Fluzone (brand name of influenza [flu - a viral infection of the lungs, nose and throat that can be deadly specially in high risk people]) vaccine multidose vials ([MDV]-vials containing more than one dose of medication) was found stored in the refrigerator and not labeled with a date when the vial was used/opened. According to the manufacturer's product storage and labeling, open Fluzone MDV's should be stored between 36 to 46 degrees Fahrenheit and discarded within 28 days of opening or using the vial. 2. One open and expired Humalog (type of insulin) insulin vial for Resident 324 in the refrigerator labeled with an open date of 1/6/20. According to the manufacturer's product storage and labeling, opened Humalog insulin vials can be stored at room temperature below 86 degrees Fahrenheit or refrigerated between 36 to 46 degrees Fahrenheit, and used or discarded within 28 days of opening vial. 3. One expired emergency medication kit labeled with an expiration date of 4/21. According to pharmacy label and facility policy, expired emergency medication kits should not be used and discarded by the labeled expiration date. On 05/6/21 at 1:12 PM, during an interview, LVN3 stated flu vaccine was not labeled when it was opened, and that it was past 28 days since the Humalog vial was opened. LVN3 stated both medications are considered expired and should be discarded. LVN3 stated all nursing shifts should check for expired medications and emergency kits and dispose them. LVN3 stated the facility failed to dispose of expired medications and emergency kits. LVN3 stated expired insulin has low potency (full power) and giving expired insulin to residents means they will not receive the full dose and not help with their blood sugars, have low or high blood sugars, get hospitalized , and possibly die. LVN3 stated the influenza vaccine is considered expired and if used for residents will not give them the protection they need against the flu. LVN3 stated if not protected then the residents will be vulnerable to getting the flu, having complications and adverse effects from the flu, and possibly dying. LVN3 stated the emergency medication was expired since the end of April and it should have been replaced with a new kit from the pharmacy. LVN3 stated emergency medications are needed in emergency situations and used from the emergency medication kits. LVN3 stated giving residents expired medications during emergency situations will only make the situation worse and lead to resident death. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/7/21 at 9:40 AM, during an interview, the Administrator (ADMIN) stated the emergency medication kits should be checked daily for expiration dates, and if the kits are opened or expired should be addressed the same day by replacing with new ones from the pharmacy. The ADMIN stated that medication refrigerator temperature logs should be checked twice daily to make sure the temperature is in the appropriate range for the medications, so they maintain their effectiveness. The ADMIN stated the facility failed to check the expiration dates and dispose of expired emergency medication kits from the medication room. The ADMIN acknowledged the second refrigerator in Station 3 medication room did not have a record or log for the monitoring of the temperatures and stated that the medications should be discarded. On 5/7/21 at 11:43 AM, during an observation of Medication Cart Station 1, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, expired and not discarded, or stored and labeled contrary to facility policies: 1. One unopened Humulin R (A brand name for a type of insulin injection) vial for Resident 10 was found stored at room temperature and not labeled with a date on which storage at room temperature began. According to the manufacturer's product labeling, unopened Humulin R insulin vials should be stored in the refrigerator between 36 and 46 degrees Fahrenheit and used or discarded within 31 days of opening or once they've been stored at room temperature. 2. One open Lantus Solostar pen (a brand name for a type of insulin injection device) for Resident 11 was found stored at room temperature and not labeled with a date on which storage at room temperature began. According to the manufacturer's product labeling, open Lantus Solostar pens should be stored at room temperature up to 86 degrees Fahrenheit and used or discarded within 28 days of opening or storing at room temperature. 3. One Hydrocodone/APAP 5-325 mg tablet medication bubble pack for resident 39 was found stored at room temperature labeled with an expiration date of 12/08/20. According to manufacturer's specifications, facility policy, and pharmacy label, expired medications should not be used and discarded. On 5/7/21 at 12:12 PM, during an interview, LVN4 stated that the insulin vials and pens are not stored properly and are expired because they are not labeled with an open use date to know when they should be discarded and not used. LVN4 stated she should not administer expire insulin to residents because they will not be effective and will not work to stabilize the residents blood sugar levels. LVN4 stated the expired insulins will cause the resident to have adverse effects such as low or high blood sugar levels, coma, and hospitalization s. LVN4 stated that the pain medication had expired on 12/8/20 and using this medication would not relieve the resident's pain. LVN4 stated that the resident would continue to have pain that can get worse, causing the resident harm. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/11/21 at 11:51 AM, during an interview, DON2 stated that expired narcotic medications have lost their potency. The DON2 stated that administering expired narcotic to residents will not control their pain, cause them more suffering from the pain, and potentially require them to have to take more potent narcotics to relieve their pain. The DON2 stated that uncontrolled pain will get in the way of residents' quality of life. The DON2 stated that the insulin vial and pens found in Medication 1, 3 and yellow zone medication room were stored inappropriately, and they are considered expired. The DON2 stated that MDV are good for 28 days, and when used beyond the 28 days their potency is not maintained and will not be effective controlling the residents' BS levels. The DON2 also stated that MDV used beyond 28 days can leads to contamination and infection for the residents. The DON2 stated that the Advair with a medication dose counter showing 000 indicates there is no more medication left in the device. The DON2 stated that a new Advair should be ordered from pharmacy. The DON2 stated that Advair is a long acting medication needed for Asthma (a condition that makes breathing difficult). The DON2 stated administering a medication that potentially not delivering the full dose to the resident will not work to treat the breathing difficulty and lead the resident to have an asthma attack and get hospitalized . The DON2 stated that the Vancomycin and Penicillin G antibiotics were expired and not effective in treating the residents' infection, which will make the infection worse, possibly lead to sepsis (a life-threatening complication of an infection), hospitalization and death. The DON2 stated that expired influenza vaccines will not provide protection against the flu and put the residents at risk of getting the flu and potentially dying. The DON2 stated that the emergency medication kit found in the yellow zone medication room indicates it is expired. The DON2 stated that the medications in the emergency kit are used during emergency situations and administering expired medications to residents during an emergency can make the situation worse, possibly causing the resident to get hospitalized and die. The DON2 stated that the second refrigerator in Medication Room station 3 does not have a log to monitor the temperature of the medications that are stored inside. The DON2 stated that if there are no temperature monitoring logs then it will not be known if the medications were being maintained at the temperature ranges specified by the medication manufacturer. The DON2 stated that if the temperature of the refrigerator is below or above the designated range then the potency and quality of the medications will be affected. The DON2 stated that if the temperature of the medications are not being monitored then they are considered expired and should not be administered to residents, because giving expired medications will not be effective in treating the residents condition and possibly make the condition worse and harm the resident. Review of facility's policy titled Administering Medications, dated April 2019, indicated that The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. Review of facility's policy titled Storage of Medication, dated April 2008, indicated that 1. Medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. 2. Medications requiring storage at 'room temperature' are kept at temperature ranging from 15 degrees Celsius (59 degrees Fahrenheit) to 30 degrees Celsius (86 degrees Fahrenheit). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Medications requiring 'refrigeration' or 'temperatures between 2 degrees Celsius (36 degrees Fahrenheit) and 8 degrees Celsius (46 degrees Fahrenheit)' are kept in a refrigerator with a thermometer to allow temperature monitoring. 4. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. Review of facility's policy titled Labeling of Medication Containers dated April 2019 indicated that: 1. Labels for individual resident medications include all necessary information, such as .the expiration date when applicable 2. Labels for stock medications include all the necessary information, such as .the expiration date when applicable . Review of facility's document titled Insulin Administration, dated September 2014, indicated to Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening. Review of facility's undated document titled Guide for Special Handling of Medications indicated: 1. insulin products (except Levemir, Novolin R, Novolin N, Novolin 70/30) to store unopened vials in the refrigerator. May store opened vials at room temperature or in the refrigerator. Discard 28 days after opening or removed from refrigeration. 2. Insulin pens and cartridges to store at room temperature and do not refrigerate after opening. Expiration dates vary by manufacturer. Multi dose vials for injection to discard 28 days after opening. 3. Multi dose vials for injection to discard 28 days after opening. Review of facilities policy titled Emergency Medications, dated April 2007, indicated that The Consultant Pharmacist shall inspect the emergency medication kits monthly and record the findings on the record maintained with each kit. Review of facility's policy titled Emergency Pharmacy Service and Emergency Kits, dated April 2008, indicated that The kits are checked by a pharmacist at least monthly.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36394 Based on interview and record review the facility failed to ensure laboratory test for potassium (a substance found in some foods and medications that help the body to work properly) was obtained as ordered by the physician for one of one resident (Resident 59). This deficient practice had the potential to result in low or high levels of potassium in Resident 59's blood. Findings: On 05/11/21, at 11:38 a. m., during an interview, the Director of Staff Development (DSD) stated not following Resident 59's physician's order for potassium levels every 6 months placed the resident at risk of potassium toxicity and confusion. On 05/11/21, at 12 p. m., during a concurrent interview and review of Resident 59's Medication Regimen Review (MRR) dated 3/1/2021 to 3/31/2021, the Quality Assurance Nurse (QAN) stated the pharmacist's indicated lab work was not found in the chart as ordered for the resident's potassium to be drawn every six months. QAN stated the staff failed to follow Resident 59's physician's routine order. QAN also stated this failure could cause Resident 59 to have a heart attack. A review of Resident 59's Face Sheet indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] Resident 59's diagnoses included Chronic Kidney disease (inability of the kidney to function like they normally should) and Hyperkalemia (high potassium levels). A review of the physician's order summary dated 5/6/2021, indicated Resident 59's potassium level will be checked every six months. A review of Resident 59's physician's order dated 5/6/2021, indicated potassium chloride extended release 10 milliequivalent. ([mEq] unit of measurement), Give one tablet by mouth (PO) one time a day (QD) for supplement, with food and a full glass of water. A review of Resident 59's medical records dated 2/17/2020 indicated the resident had a potassium blood level of 4.8 mEq /per liter (unit of measurement).

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41489 Based on observation, interview, and record review the facility to provide food at a palatable, attractive, and appetizing temperature for four of four sampled Residents by: a. Ensuring Resident 222's vegetable and grilled cheese sandwich were not served cold. b. Ensuring Resident 2 was not served food that was ugly and looked like dog food and is rubbery. c. Ensuring Resident 18's daily meals for breakfast, lunch, and dinner were not served cold. d. Ensuring Resident 31's breakfast was not served cold. This deficient practice had the potential to result in decreased nutritional intake resulting in the development of pressure injuries (damage to skin and underlying tissue over bony areas), and delayed recovery from illness. Findings: a. A review of Resident 222's undated admission record indicated the facility originally admitted Resident 222 on 3/9/2016 and readmitted on [DATE]. Resident 2's diagnosis included chronic obstructive pulmonary disease (COPD [group of diseases that block airflow and make it difficult to breathe]), diabetes mellitus (condition that effects the way the body processes blood sugar), and non-pressure chronic ulcer (open sore resulting from breakdown of the skin and tissues.) A review of Resident 222's Minimum Data Set (MDS), a standardized assessment and care-planning tool, dated 2/12/2021, indicated Resident 18 had no cognitive (understanding and knowledge) impairment. During an interview on 05/06/21 at 10:50 a.m., Resident 222 stated, The food is sometimes not cooked all the way. My food is served lukewarm. It is like this for all of my meals. During an observation and a concurrent interview on 05/06/21 at 12:42 p.m., Resident 222 received her food tray. Resident 222 touched her vegetables and grilled cheese sandwich and stated the food is cold. During an observation and a concurrent interview on 05/07/21 at 09:06 a.m., Resident 222 stated her eggs were cold, but she did not tell anyone because she is used to eating cold food. During an interview on 05/07/21 at 10:38 a.m., a certified nurse assistant (CNA 9) acknowledged that CNAs are responsible for delivering the food trays to the residents. CNA 9 stated the food cart is brought to the end of the hallway and no trays are delivered until a licensed vocational nurse (LVN) verifies each tray for correctness. The CNA stated the LVN compares the diet order with the tray and the Resident name to verify they match. The CNA stated it takes approximately 15 to 20 minutes to deliver the food to all the Residents rooms in this hallway. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/7/21 at 11:12 a.m., CNA 8 stated Some residents do not like the eggs. When I pass out the trays, they are hot but sometimes the trays sit awhile. It might take about 7 min to get the food to the residents. During an observation and a concurrent interview on 05/07/21 at 12:35 p.m., Resident 222's cheese quesadilla was observed being placed on food cart in kitchen. At 12:36 p.m., a grilled cheese and potato tot sample tray was prepared. At 12:44 p.m. Resident 222's food tray is taken out of kitchen. At 12:45 p.m. Resident 222's food tray arrived at the end of the hallway and had to be verified for correctness by a LVN. An LVN passes trays but does not verify the trays. At 12:49 p.m., two CNAs attempt to locate an LVN to verify the residents' food trays. At 12:51 p.m. the LVN returns to verify the residents' food trays for correctness. The LVN completes the verification at 12:56 p.m. At 1:05 p.m, Resident 222's food tray is delivered. Resident 222 touches her cheese quesadilla and states Everything is cold, but I will eat anyway. b. A review of Resident 2's undated admission record indicated the facility originally admitted Resident 2 on 6/21/2017 and readmitted on [DATE]. Resident 2's diagnosis included hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis of one side of the body), muscle weakness, type 2 Diabetes (a condition that effects the way the body processes blood sugar), and seizures (bursts of uncontrolled electrical activity in the brain that causes abnormalities in muscle tone or movements). A review of Resident 2's MDS dated [DATE], indicated Resident 18 had no cognitive impairment. A review of Resident 2's physician's Orders dated 10/13/2018, indicated the physician ordered a reduced concentrated sweets (RCS), no added salt, and regular texture diet. A review of Resident 2's dietary profile/preferences form dated 4/14/21, indicated Resident 2 had not been served food to her liking. The dietary profile indicated that Resident 2 stated, At times I don't like the food, but I ask for a substitute and I get it all the time. During an interview on 05/06/21 at 10:38 a.m., Resident 2 stated, The food is ugly It looks like dog food and is rubbery. They will only replace it with peanut butter. I just eat it because I'm tired asking for different food. I see them bring my roommate's food and just leave the food without feeding her. During an observation and a concurrent interview on 05/07/21 at 1:16 p.m., Resident 2 stated, My food is hard as a rock. It is warm but inedible. It's too hard. This is chicken, a biscuit and veg (vegetables). The biscuit is wet. Upon observation, the chicken patty appears to be dry and hard. Resident 2 tries to cut chicken the patty and has difficulty. The biscuit is wet and appears mushy at the bottom. During an interview on 05/10/21 at 1:01 p.m., the Dietary Supervisor (DS) acknowledged that Resident 2 requests different food frequently and the facility provides alternatives. The DS could not verbalize whether the alternatives were acceptable to Resident 2. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. A review of Resident 18's undated admission record indicated the facility originally admitted Resident 18 on 10/16/2019 and was readmitted on [DATE]. Resident 18's diagnoses included unstable angina (condition which the heart does not get enough blood flow and causes unexpected chest pain), COPD, and cardiomegaly (condition in which the heart is enlarged). A review of Resident 18's MDS, dated [DATE], indicated Resident 18 had no cognitive impairment. A review of Resident 18's physician's orders dated 3/31/2021, indicated the physician ordered a RCS with a regular texture, thin consistency, and no salt added diet. A review of the Resident Council Minutes dated 3/9/2021, indicated Resident 18 stated, the food is cold. During an interview on 05/06/21 at 09:02 a.m., Resident 18 stated My food is cold for all three meals and I don't eat cold food. d. A review of Resident 31's undated admission record indicated the facility originally admitted Resident 31 on 12/1/2020 and was readmitted on [DATE]. Resident 31's's diagnoses included cellulitis (bacterial infection involving the inner layers of the skin) of the right lower limb, difficulty walking, type 2 diabetes, and necrotizing fasciitis (a bacterial infection that destroys tissue under the skin.) A review of Resident 31's MDS, dated [DATE], indicated Resident 31 had no cognitive impairment. During an interview on 05/07/21 at 09:09 a.m., Resident 31 stated My food was fine this morning but its normally cold. Most people would send it back. Lunch is okay and dinner is okay but in the mornings my eggs and food are always cold. The trays sit outside for a long time. Breakfast is served at 7:30 a.m. but we don't get it until about 20 min after they put the tray out on the cart and I'm right across from the kitchen. Sometimes I get it from the cart myself because I am tired waiting. They have the food on the cart and it just sits there. A review of the facility's policy and procedure (P/P) titled, Food and Nutrition Services, revised October 2017, indicated, Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature.

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	056415	A. Building B. Wing	05/11/2021

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43955 Based on observation, interview and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety and prepare foods free of visible signs of insects or rodents, when the following was observed: 1. Potatoes with green sprouts 2. One molded orange 3. Three oranges with dry brown dark spots. 4. An entire bundle of bananas with dark brown spots. 5. Gnats were flying on one sunken cantaloupe. 6. Old wilted fruit (multiple oranges, bananas and cantaloups) and vegetables (brown and red potatoes) were observed in a box under the storage cabinet. 7. Three old potatoes under the fruit and vegetable storage cabinet on the floor This deficient practice had the potential to cause a wide spread of foodborne illness and bacterial infections among resident's receiving food services in the facility. Findings: During kitchen observations, on 5/5/21 at 10:36 a.m., the following was observed and confirmed by DS the following observations: 1. Potatoes with green sprouts 2. One molded orange 3. Three oranges with dry brown dark spots. 4. An entire bundle of bananas with dark brown spots. 5. Gnats were flying on one sunken cantaloupe. 6. Old wilted fruit (multiple oranges, bananas and cantaloups) and vegetables (brown and red potatoes) were observed in a box under the storage cabinet. 7. Three old potatoes under the fruit and vegetable storage cabinet on the floor (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Dietary Supervisor (DS) on the same day at 10:38 a.m., stated when shown and asked what was the issue with the cantaloupe, he states that's mold, when asked about the appearance of the oranges he states that's old. DS was asked to describe the potatoes and he states that they are also old. DS stated, he has a responsibility to supervise food service for patients, employees, and visitors in a nursing home environment. Reviews menus and supervises the handling, preparation, and storage of food and assign work schedules for food services employees. The DS stated that residents could become sick if they were to be served fruits and vegetables that are old and have mold on them. A review of the facility's pest control service report, dated 5/3/21, showed a pest management service had rendered services to the facility for gnats on 3/1/21,3/23.21,4/5/21,4/27/21 and 5/3/21. The DS stated they had been having issues and have been receiving pest control services for the gnats. During a review of the facility's policy and procedure titled Preventing Foodborne Illness-Safety and dated disclosed the facility strives to minimize the risk of foodborne illness to the resident's, by maintaining clean food storage at all times.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36394 Based on interview and record review the facility failed to implement its quality assurance, planning and implementation policy (QAPI) by: 1. Not identifying residents receiving insulin (medication to reduce or prevent high blood sugar). 2. Not monitoring and documenting blood sugar levels for residents on insulin therapy. 3. Not administering and documenting insulin administration for 21 residents. 4. Not obtaining physician orders for monitoring hemoglobin A1C (blood test that measures blood sugar levels over the past 3 months) for 9 out of 21 residents (Residents 2, 7, 11, 25, 26, 41, 57, 172, and 173). 5. Not implementing a physician's order for monitoring routine laboratory test every six months for 1 out of one resident (Resident 59). 6. Not acting on pharmacy consultant recommendations on medication regimen review irregularities for several months. 7. Not investigating a resident who had an unwitnessed fall. These deficient practices placed residents at risk for injuries, comma or death. Findings: On 5/11/21 at 4 PM, during an interview the Minimum Data Set Nurse (MDS) stated after a thorough search Resident 2, 7, 11, 25, 26, 41, 57, 172, and 173's medical records, there were no physicians' orders and lab results for HgA1c. a.A review of Resident 2's Admission Record, dated 5/10/21, indicated the resident was admitted to the facility on [DATE] with a diagnosis including diabetes (high blood sugar). A review of Resident 2's Medication Administration Record (MAR) for April and May 2021, indicated the resident was prescribed insulin Lantus (medication to decrease blood sugar levels) 20 units (a unit of measurement) in the morning, and Regular insulin per sliding scale (insulin dose dependent on the BS level) subcutaneous ([SQ] under the skin) before meals (AC) and at bedtime (HS). A review of Resident 2's clinical chart did not contain a record for HgA1c level physician order or laboratory results since admission on 6/21/17. b. A review of Resident 7's admission record indicated the resident was initially admitted to the facility on [DATE] with diagnoses including diabetes. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 7's Order Summary Report, dated 5/10/21, indicated the resident was prescribed Glargine (type of insulin) 5 units subcutaneous daily. The order also indicated to administer Regular insulin per sliding scale SQ three times a day AC and HS. d. A review of Resident 11's admission record indicated the resident was initially admitted to the facility on [DATE] with a diagnosis including diabetes. A review of Resident 11's order summary report dated 5/10/21, indicated the resident was receiving Basaglar Kwikpen (type of insulin) 20 units subcutaneous two times a day (BID), Lantus 20 units SQ BID and Regular insulin as per sliding scale SQ AC and HS. e. A review of Resident 25's admission record indicated the resident was admitted to the facility on [DATE] with diagnosis including diabetes. A review of Resident 25's order summary report, dated 3/2/21, indicated the resident was prescribed Humulin R (type of insulin) per sliding scale SQ three times a day (TID). f. A review of Resident 26's admission record indicated the resident was admitted to the facility on [DATE] with a diagnosis of diabetes. A review of Resident 26's order summary report, dated 4/7/21, indicated the resident was prescribed Lispro (type of insulin) per sliding scale SQ, AC and HS. g. A review of Resident 41's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including diabetes. A review of Resident 41's order summary report dated 9/14/20 indicated the resident was prescribed Glargine 5 units SQ BID. h. A review of Resident 57's admission record indicated the resident was admitted to the facility on [DATE] with diagnosis including diabetes. A review of Resident 57's order summary report dated 1/10/21 indicated the resident was prescribed Glargine 15 units SQ BID. i. A review of Resident 172's admission record indicated the resident was admitted to the facility on [DATE] with a diagnosis including diabetes. A review of Resident 172's order summary report dated 4/3/21 indicated the resident was prescribed Glargine SQ at HS. j. A review of Resident 173's admission record indicated the resident was admitted to the facility on [DATE] with a diagnosis including diabetes. A review of Resident 173's order summary report dated 4/22/21, indicated the resident was prescribed Humulin R (type of insulin) per sliding scale SQ and HS. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. A review of Resident 59's Face Sheet indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 59's diagnoses included Chronic Kidney disease (inability of the kidney to function like they normally should) and Hyperkalemia (high potassium levels). On 05/11/21, at 12 p. m., during a concurrent interview and review of Resident 59's Medication Regimen Review (MRR) dated 3/1/2021 to 3/31/2021, the Quality Assurance Nurse (QAN) stated the pharmacist's indicated lab work was not found in the chart as ordered for the resident's potassium to be drawn every six months. QAN stated the staff failed to follow Resident 59's physician's routine order. QAN also stated this failure could cause Resident 59 to have a heart attack. A review of the physician's order summary dated 5/6/2021, indicated Resident 59's potassium level will be checked every six months. A review of Resident 59's physician's order dated 5/6/2021, indicated potassium chloride extended release 10 milliequivalent. ([mEq] unit of measurement), Give one tablet by mouth (PO) one time a day (QD) for supplement, with food and a full glass of water. A review of Resident 59's medical records dated 2/17/2020 indicated potassium blood level of 4.8 mEq /per liter (unit of measurement). On 05/11/21, at 1:28 p. m., during a QAPI interview, the Administrator (ADM) stated the facility used a spread sheet to track all identified issues such as falls, antibiotic use, and in-house pressure ulcers. The ADM also stated the QAPI team met monthly and the Director of Nursing (DON) discussed all nursing issues. The ADM stated he had only working in the facility for a month and was still looking into critical concerns. According to the ADM, not monitoring blood sugar levels, administering insulin for several residents could result in serious harm. The ADM added that the Quality Assurance Nurse (QAA) did not identify these issues until yesterday 5/10/2021, after surveyors brought it to the facility's attention. A review of the facility's undated QAPI policy indicated it shall focus on systems and processes on identifying system gaps and follow-up on areas of opportunities.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 39028 Based on observation, interviews, and record review facility failed to ensure one of one sampled residents (Resident 60) had the call light within reach. This deficient practice had the potential for accidents, including falls, and resulted in the delay of assisting Resident 60 with a drink of water. Findings: A review of Resident 60's undated admission record indicated the facility admitted Resident 60 on 4/11/21. Resident 60's diagnoses included acquired absence of right leg below knee, muscle weakness, gangrene (tissue death caused by lack of blood supply), sepsis (A life-threatening complication of an infection). A review of Resident 60's Minimum Data Set (MDS), an assessment and care-screening tool, dated 4/18/21, indicated the Resident 60 had impaired cognition (does not have full capacity to understand or to be understood by others). Resident 60 required extensive assistance from staff with bed mobility, transferring to and from bed, chair or a standing position, moving from one location to another, dressing, eating, toilet use, and personal hygiene. A review of care plan for activities of daily living (ADL - activities necessary for independent living), dated 4/12/21, indicated Resident 60 had a self-care deficit. The care plan indicated Resident 60 required extensive assistance from staff for ADLs. There care plan indicated that staff were to encourage the use of the call light for assistance and to extensively assist Resident 60 with eating and hydration needs. On 5/5/21, at 11:35 A.M., during the facility tour, Resident 60 was observed raising their right hand. During a concurrent interview with Resident 60, Resident 60 stated he needed help getting up and needed to drink water. Resident 60's call light was observed behind the head of bed. Resident 60 stated he did not know where the call light was. Following a subsequent observation and concurrent interview with a director of nursing (DON 1), DON 1 confirmed that Resident 60's call light was placed behind Resident 60's head of bed and was not within reach. Resident 60 verbalized to DON 1 that he could not reach the call light and needed a drink of water. DON 1 was observed to move the call light within reach for Resident 60 allowing Resident 60 to use the call light. Once a certified nurse assistant (CNA 2) responded, CNA 2 acknowledged that Resident 60's call light was supposed to be placed within reach to avoid accidents and resident been frustrated calling for help. Review of the policy and procedure titled, Answering Call Light, dated 3/2021, indicated to ensure when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.