STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056431	A. Building B. Wing	05/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36943 Based on observation, interview, and record review, the facility failed to provide an environment that promoted the dignity and respect during meals for one of 35 sampled residents (Resident 75) as indicated in the facility's policy and procedure. This deficient practice had the potential to negatively impact the resident's psychosocial well-being. Findings: A review of Resident 75's Face Sheet (Admission Record) indicated the facility admitted Resident 75 on 4/19/2019 and readmitted the resident on 11/15/2019 from a general acute care hospital (GACH) with diagnoses of right intertrochanteric femur fracture (broken hip), dementia (loss of memory and other mental abilities severe enough to interfere with daily life), and history of falling A review of Resident 75's Minimum Data Set (MDS, a comprehensive care planning tool), dated 2/18/2021, indicated Resident 75 was totally dependent for eating and required one person to assist. During an observation on 5/3/2021, at 12:33 p.m., Resident 75 was eating lunch while lying in bed with the head of bed elevated. Certified Nursing Assistant 5 (CNA 5) was feeding Resident 75 while standing to the right side and behind the resident. The height of CNA 5's face was approximately two-feet above Resident 75. During an interview on 5/4/2021, at 8:32 a.m., the facility's Director of Staff Development (DSD) stated the facility staff who assisted any residents with feeding including Resident 75, were supposed to sit at eye level which was important for communication and safety to prevent choking. During an interview on 5/4/2021 at 9:06 a.m., DSD stated the facility did not have a written policy and procedure for feeding residents who needed assistance. A review of the undated nursing assisting skill competency, titled Feeding a Resident, indicated to Sit down next to the resident.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33670 Based on interview and record review the facility failed to ensure the Resident's responsible party (RP) receive information on resident's clinical condition, healthcare information and plan of care for one of 35 sampled Residents (Resident 187). This failure had the potential to violate the resident's or RP's rights to be informed and to choose the type of care or treatment to be received, or alternatives the resident or responsible party preferred. Findings: A review of the Face Sheet (Admission Record) indicated Resident 187 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). A review of the Minimum Data Set (MDS, standardized assessment and care screening tool), dated 1/11/21, indicated Resident 187 was unable to speak and was severely impaired with cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. During a telephone interview, on 5/3/21 at 12:16 PM with Resident 187 family (FAM 1), she stated she and other family members were not updated or informed of Resident 187's change of condition for months. FAM 1 stated, for the past six months when she would call the facility to inquire about Resident 187's status, the phone would ring repeatedly and no one would answer the phone. FAM 1stated if the call was answered, it would be transferred to another area and eventually the call would drop. FAM 1 stated the facility does not call. During an observation and interview on 5/4/21, at 10:41 AM, with Licensed Vocational Nurse (LVN17), Resident 187 was observed lying in bed and was unable to speak and make needs known when spoken to. LVN17 stated she had not spoken to any family members about Resident 187's condition. During an interview on 5/6/2, at 11:47 AM, with the Assistant Director of Nursing (ADON), she stated, it was important for the RPs to be updated with the residents' healthcare condition so they can make healthcare decision to ensure the residents' rights were implemented. During an interview and concurrent interview on 5/7/21 at 11:30 AM, with the Social Service Designee 1 (SSD 1) and SSD 2, they stated they were not aware why the Social Service Director (SSD) did not inform or invite Resident 187's RP to the quarterly IDT (Interdisciplinary Team, involving two or more disciplines or fields of study) meeting to discuss Resident 187's change of condition or treatments from 1/2021 to present. SSD 1 stated there was no record to indicate Resident 187's RP participated in any zoom meeting. During an interview on 5/7/21, at 12:30 PM, with the Administrator (ADM), she stated, there were issues about the internet problem in the facility, which causes the incoming calls to drop or get disconnected. ADM stated this could be the reason for the phone calls of the RPs to be lost or not answered. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/07/21, at 1:03 PM with the DON, she stated the concern regarding the internet connection and phone lines were brought to the Quality Assurance Program Improvement Commitee last quarter, but they remain to be a problem.

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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** 33670 Based on observation, interview and record review, the facility failed to reasonably accommodate the needs of five of 35 sampled Residents (Residents 4, 27,75, 93 and 649) by: a.b Residents 4 and 27's call light were not answered timely. c. Resident 75's call light was not within reach. Resident 75 complained of being cold during the entire bed bath and the staff ignored her. d. Resident 649's call light was not within reach and was found on the floor. e. Resident 93's call light was not answered timely. This deficient practice had the potential for the residents not to be able to call the staff for assistance, which could result to not receiving or delayed needed care or services necessary for the residents' well-being. Cross reference F725 Findings: a. A review of the Face Sheet (Admission Record) indicated Resident 4 was admitted on [DATE] with diagnosis of cerebral infarction (brain tissue damage due to a loss of oxygen to the area). A review of Resident 4's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 4/14/21, indicated Resident 4's cognition was intact. Resident 4 required extensive assistance with a one-person physical assist to perform activities of daily living (ADL) such as toileting and personal hygiene. During an interview on 5/07/21, at 8:10 AM, Resident 4 stated, about three months ago, whenever he would press the call light for a diaper change, the Certified Nurse Assistant (CNA) would come to the room and tell him that he/she would be right back but the CNA does not return until 30 minutes later. Resident 4 stated this happened about three times. A review of the facility's policy titled, Quality of Life - Accommodation of Needs, revised in 8/2009 indicated that the staff should interact with the residents in a way that accommodates the physical or sensory limitations of the residents. The policy indicated that the staff behaviors are directed toward assisting the residents in maintaining dignity and well-being. b. A review of the Face Sheet indicated Resident 27 was admitted to the facility on [DATE]. Resident 27's diagnoses included atrial fibrillation (irregular heart beat) and neuralgia (an intense, typically intermittent pain along the course of a nerve, especially in the head or face). (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 the MDS, dated [DATE], indicated Resident 27 had no impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 27 required limited assistance with personal hygiene and total assistance with one person for toilet use. Resident 27 had limited range of motion on both lower extremities. During an interview on 5/3/21 at 12:38 pm, Resident 27 stated, the facility staff does not answer the call light half of the time when she needed assistance to change her brief, wash up or toilet use. Resident 27 stated she reported the concern to the charge nurses, but it is still a problem. During a concurrent observation and interview on 5/7/21, at 9:48 a.m., Resident 27's call light was on and there was no staff observed in the hallway. Resident 27 stated she had been waiting for more than 15 minutes for the staff to come back to bring her towels and to assist with washing her face and body. During an interview on 5/7/21, at 11:32 a.m. the Director of Nursing (DON) stated the call lights should be answered timely to meet the resident's needs. A review of the facility's policy and procedure, titled Accommodation of Needs-Quality of Life, dated 8/2009, indicated the resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. 28074 c.1 A review of the Face Sheet indicated Resident 75 was admitted to the facility on [DATE]. Resident 75 diagnoses included were fracture (broken bone) of the right femur (thighbone), chronic obstructive pulmonary disease (COPD, progressive disease that gets worse over time and makes it hard to breath), dementia (gradual loss of brain function and a decline in mental functioning) and psychosis (severe mental disorder in which you lose touch with reality). A review of the MDS, dated [DATE], indicated Resident 75 had short and long-term memory problems, was able to make herself understood and had the ability to understand others. Resident 75 required total assistance with activities of daily living. During observation on 5/3/21, at 10:39 am, two staff were observed assisting Resident 75 with bed bath. During this observation, Resident 75 told the staff twice that she was feeling cold. On both times, the staff ignored Resident 75 and told the resident the water was warm. One of the staff covered Resident 75's upper torso with another towel leaving the lower torso exposed. No other covering was given to the resident to prevent her from feeling cold. During an interview, after Resident 75's bed bath, on 5/3/21, at 11 am, both CNAs stated Resident 75 complained too much especially during bed bath. They both stated that they should have provided the resident a bed blanket instead of just a towel. During an interview on 5/3/21, at 11:26 a.m., Licensed Vocational Nurse 7 (LVN 7) stated a bed blanket should have been provided for warmth and privacy. (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 the facility's policy and procedure, titled Bed Bath, revised on 2/2018, indicated not to expose the resident and to use bed blanket during bed bath. c.2. During an observation on 5/3/21, at 10: 45 am, Resident 75 was lying in bed with her call light not within reach. During an interview, Resident 75 stated she never had the call light with her because it was never given to her. Resident 75 added she could have used it to call for assistance especially if she needed assistance in repositioning herself. During a concurrent observation and interview on 5/3/21, at 10:50 am, with CNA 6, she confirmed the call light was not with the Resident 75's reach. CNA 6 looked around and found the call light behind the resident's head of bed. During an interview with LVN 7 on 5/6/21, at 3:04 pm, she stated the call light should always be reachable. A review of the facility's policy and procedure, Answering the Call light, revised 10/2010, indicated, when the resident is in bed or confined to a chair be sure the call light is within reach. 44290 d. A review of the Face Sheet indicated Resident 649 was admitted to the facility on [DATE] with diagnosis of left side hemiplegia (paralysis to one side of the body) following cerebral infarction. A review of the MDS, dated [DATE], indicated Resident 649 was able to express his ideas and wants and understands others. Resident 649 required extensive assistance with one person assist for bed mobility and total assistance with transfer, toilet use, and personal hygiene. During a concurrent interview and observation on 5/3/21 at 9:36 am, Resident 649 stated, I don't know where that thing is. The call light was observed hanging from the wall on the floor and not within Resident 649's reach. During a review of Resident 649's Care Plan, titled, ADL, dated 4/12/21, included intervention to have call light within reach and staff to answer promptly. A review of the facility's policy titled, Quality of Life - Accommodation of Needs, revised in August 2009 indicated that the staff should interact with the residents in a way that accommodates the physical or sensory limitations of the residents. The policy indicated that the staff behaviors are directed toward assisting the residents in maintaining dignity and well-being. e. A review of the Face Sheet indicated Resident 93 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of hemiplegia (paralysis of one side of the body) following cerebral infarction affecting the left non-dominant side. A review of Resident 93's MDS, dated [DATE], indicated Resident 93's cognition was mildly impaired. Resident 93 required extensive assistance with a two-person physical assist to perform ADL such as toileting. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/07/21, at 8:15 AM, Resident 93 stated, whenever he would press the call light for a diaper change, he ends up falling asleep while waiting for the CNA. Resident 93 added, on other occasions, the CNA would answer the call light and tell him that he would be back, but the CNA does not return until 30-45 minutes later. A review of the facility's policy titled, Quality of Life - Accommodation of Needs, revised in August 2009 indicated that the staff should interact with the residents in a way that accommodates the physical or sensory limitations of the residents. The policy indicated that the staff behaviors are directed toward assisting the residents in maintaining dignity and well-being.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 44027 Based on observation, interview, and record review, the facility failed to maintain normal water temperatures. This deficient practice had the potential for the residents to experience uncomfortable water temperatures. Findings: 1. During an interview on 5/5/21, at 9:15 AM, Resident 40 stated the hot water temperature for bed baths (a cleansing of a person in bed) has been too cold for months. During an observation, on 5/5/21, at 9:15 AM, in the bathroom of room A, the hot water temperature from the faucet was 96.3 degrees Fahrenheit (F - a scale of temperature measurement) using a digital thermometer. During a concurrent observation and interview, on 5/5/21, at 9:20 AM, in the bathroom of Room A, the Maintenance Supervisor recorded a water temperature of 101 degrees F using a dial thermometer. Maintenance supervisor stated the hot water temperature should register between 105 and 120 degrees F. During a concurrent observation and interview, on 5/5/21, at 9:23 AM, in the bathroom of Room B, the hot water temperature was 78.5 degrees F using the digital thermometer. 2. During an interview, on 5/5/21, at 1:32 PM, Resident 131 stated when Nursing staff offers shower at around 3:30 PM, she doesn't take a shower because the water is too cold. Resident 131 stated she waits until Saturday mornings because the water is warmer. Resident 131 stated it makes her feel sad and dirty when she can't take a hot shower. During a concurrent observation and interview, on 5/7/21, at 8:56 AM, upon entering Room A, Maintenance Supervisor checked the hot water temperature from the bathroom faucet. The initial water temperature was measured at 96.4 degrees F. The water temperature was 100.0 degrees Fahrenheit after 5 minutes. This bathroom is shared between Room C and Room A. There were 2 residents in each room. During a concurrent observation and interview, on 5/7/21, at 9:05 AM, with the Maintenance Supervisor, the hot water temperature from the bathroom faucet was measured at 125.0 degrees F. During a concurrent observation and interview, on 5/5/21, at 11:30 AM, Maintenance supervisor showed the boiler (a closed container in which water is heated) room. Maintenance supervisor cannot show where the temperature settings are on the 2 boilers in the room. Maintenance supervisor stated he does not know what the temperature settings are or how to change the temperature settings. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy and procedure titled, Safety of Water Temperature, revised on 12/2009, indicated water heaters that service resident rooms, bathrooms, common areas , and tub/shower areas shall be set to temperature of no more that 120 F, or the maximum allowable temperature per state regulation.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 28074 Based on interview and record review, the facility failed to indicate in writing the address where three of three sampled residents (Residents 249, 250, and 253) were discharged to. This deficient practice had the potential for the residents who left the facility not knowing whether their destination was safe and not be able to receive the continuity of care they needed. Findings: a. A review of Resident 249's Admission Record indicated the facility readmitted the resident on 4/5/2021, with diagnoses of tracheostomy (surgical procedures on the neck to open a direct airway through an incision in the trachea or windpipe) and dependence on respirator (use of a machine to help in breathing). A review of Resident 249's Physicians Discharge Summary dated 4/14/2021 indicated the resident was discharged to the hospital on 4/8/2021. A review of Resident 249's Notice of Proposed Transfer and discharge date d 3/26/2021, indicated there was no address where the resident was discharged to. During an interview on 5/7/2021 at 10:27 am, Social Service Designee (SSD) 1 and 2 stated that it was the responsibility of the staff whoever discharged the resident to ensure the address to where the Resident 249 was discharged to was completed. b. A review of Resident 250's Admission Record indicated the facility readmitted the resident on 12/13/2019, with diagnoses of respiratory failure, tracheostomy and dependent on respirator. A review of Resident 250's undated Physician's Discharge summary dated 4/2/2021 indicated Resident 250 was discharged to a hospital on 4/2/2021 due to respiratory distress. A review of Resident 250's Notice of Proposed Transfer and discharge date d 4/2/2021, did not indicate the address where the resident was transferred to. During an interview with SSD 1 and 2 on 5/7/2021, at 10:30 am they both stated the staff needed to write down the address where Resident 250 was discharged to. c. A review of Resident 253's Admission Record indicated the facility admitted the resident on 3/18/2021 with diagnoses of right hand fracture (broken bone), diabetes mellitus (high sugar in the blood system) and muscle weakness. A review of Resident 253's Physician's Discharge Summary dated 4/2/2021, indicated Resident 253 was discharged home on 3/26/2021. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 253's Notice of Proposed Transfer and discharge date d 3/26/2021, indicated a post office box (PO Box) number, and not the address where the resident was discharged to. During an interview on 5/7/2021 at 10:35 am, SSD 1 stated that the address should have been written down in case there was a need for a follow up care. A review of the facility's Discharging the Resident policy and procedure with a revised date of December 2016, indicated to inform the resident where the new facility was located.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33670 Based on observation, interview and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for one of 35 sampled Residents (Resident 27). Resident 27 with hearing impairment was assessed and recorded as no hearing difficulties This had the potential for the resident not to receive the appropriate and necessary care, treatment and services, which can adversely affect quality of life Findings: A review of the Face Sheet (Admission Record) indicated Resident 27 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heart beat) and neuralgia (an intense, typically intermittent pain along the course of a nerve, especially in the head or face). A review Minimum Data Set (MDS, resident assessment and care screening tool), dated 2/2/21, indicated Resident 27 had no impairment in cognitive skills for daily decision making. The MDS also indicated Resident 27 had adequate ability to hear, no hearing aide and no difficulty with normal conversation. During an interview and concurrent observation on 5/6/21, at 9:56 AM, Resident 27 spoke loudly when answering questions and asked if the surveyor could talk to her closer to her right ear. Resident 27 stated she could not hear and she does not have a hearing device. During an interview on 5/6/21, at 10:02 AM, Licensed Vocational Nurse 3 (LVN 3) stated Resident 27 does not have a hearing device and she usually spoke to her loudly because of her hearing difficulties. During a record review and concurrent interview on 5/07/21 at 8:05 AM, the MDS Nurse stated, Resident 27 had a hearing impairment and should had been assessed as having hearing difficulty in the MDS to ensure the resident received the assistance needed for hearing.

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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** 33670 Based on observation, interview and record review the facility failed to develop and implement a comprehensive, resident specific plan of care for nine of 35 sampled Residents (Residents 27, 48, 167, 75, 133, 91, 146 and 163) a. Resident 27 did not have a care plan to address hearing difficulties. This deficient practice had resulted in the resident's difficulty in miscommunication and a potential not to receive neccessary care and services. b. Resident 48's care plan was not implemented to monitor the resident for bleeding and bruising while receiving Xarelto (a medication to prevent development of blood clot or blood thinner). c. Resident 167's care plan was not implemented to monitor the resident for bleeding and bruising while receiving Coumadin (a medication to prevent development of blood clot or blood thinner). These deficient practices had the potential for the residents to experience bleeding or bruising and result in lack of immediate care or complications related to bleeding. d. Resident 75 did not have a care plan to address skin rashes. This had the potential for the resident not to receive appropriate care and treatment and inadequate monitoring of the resident's progress and changes in condition. Resident 75 did not have a care plan to address decline in range of motion (ROM) for both legs. This resulted in Resident 75 not receiving intervention with ROM exercises to prevent contractures (chronic loss of joint motion to both legs. Cross reference F688 f. Resident 133 did not have a care plan to address resident's behavior when feeling anxiety ((a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) g. Resident 91's care plan intervention to have an audio consult was not implemented to address possible hearing impairment. h. Resident 146 did not have an individualized care plan to address the use of Ativan (anitanxiety) and the behavior of pulling out tubing. i. Resident 163 did not have an individualized care plan to address the use of Ritalin (a medication for attention deficit hyperactivity disorder). These failures had the potential for residents not to receive interventions to address specific needs, which could affect quality of life. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings: a. A review of the Face Sheet (Admission Record) indicated Resident 27 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation (irregular heart beat) and neuralgia (an intense, typically intermittent pain along the course of a nerve, especially in the head or face). A review of the Minimum Data Set (MDS, a resident assessment and care screening tool), dated 2/2/21, indicated Resident 27 had no impairment in cognitive skills for daily decision making. According to the MDS, Resident 27 had adequate ability to hear, no hearing aide and no difficulty with the normal conversation. During an interview on 5/6/21, at 9:56 AM, Resident 27 was observed with the loud voice when answering questions. Resident 27 asked if the surveyor could talk to her closer to her right ear because she could not hear and she does not have a hearing device. During an interview on 5/6/21, at 10:02 AM, Licensed Vocational Nurse 3 (LVN 3) stated Resident 27 does not have a hearing device and she usually spoke to her loudly because of her hearing difficulties. During an interview and concurrent record review on 5/7/21, at 8:05 AM , MDS Nurse 1 stated Resident 27 was hard of hearing. MDS Nurse 1 stated there was no care plan developed to indicate the interventions needed to assist the resident with the hearing difficulty and the need for hearing device. During an interview with the Certified Nursing Assistant 5 (CNA 5) on 5/7/21, 8:45 AM, she observed Resident 27 with a hearing difficulty for at least three years and she had not seen the resident use a hearing device. b. A review of the Face Sheet indicated Resident 48 was readmitted to the facility on [DATE] with diagnosis of atrial fibrillation (a heart condition that results in irregular heart rate which is a risk for developing blood clot). A review of the MDS, dated [DATE], indicated Resident 48 was able to understand others and make herself understood. Resident 48 was moderately impaired in memory and cognition (ability to think and reason). During an observation on 5/3/21, at 8:49 AM, Resident 48 was observed sleepy and unable to answer questions when interviewed. During a concurrent record review of the physician order and the Medication Administration Record (MAR) and interview with LVN 3 on 5/6/21, at 10:43 AM, she stated Resident 48 was receiving anticoagulant medication Xarelto (a medication that for blood thinner) 20 milligrams (mg) tablet one tablet by mouth at bedtime and to be given with food. A review of Resident 48's care plan titled, Anti-coagulant, dated 2/8/2, indicated Resident 48 need anticoagulant medication for atrial fibrillation and was at risk for adverse side effect (ASE) of bleeding. The plan of care indicated to minimize ASE from medication manifested by bleeding, bruising,vomiting of blood, petechiae (are pinpoint, round spots that appear on the skin as a result of bleeding) and melena (blood in the stool), Resident 48 will be monitored for ASE. (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 MDS, dated [DATE], indicated the patient had short and long-term memory problem, was able to make herself understood, and had the ability to understand others. Resident 75 required total assistance with activities of daily living. During the initial tour on 5/3/21, at 9 AM, Resident 75 was observed lying in bed. Resident 75 was observed scratching her upper body, both arms and neck. On closer observation, Resident 75 was observed with multiple raised bumps on her back, front body, both arms, neck and shoulder. Resident 75 stated she just wants the itching to stop. During a concurrent record review and interview with LVN 7 on 5/3/21, at 9:30 a.m., she stated Resident 7 has been receiving cream for the skin rashes. LVN 7 stated there was no care plan developed for Resident 75's skin rashes. A review of the physician's order dated 4/13/21, indicated Naftifine Hydrochloride (antifungal) 2 % cream to apply to affected areas, bilateral thighs and bilateral arms two times a day (BID) for 4 weeks for contact dermatitis. The physician also had ordered Flucinonide 0.1 5 cream , apply to affected areas, bilateral thighs and bilateral arms BID for 4 weeks. A review of the facility's policy and procedure, titled Care Plans-Comprehensive dated 9/2010, indicated, The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met. 36943 e. A review of Resident 75's Face Sheet indicated Resident 75 was readmitted to the facility on [DATE] from the GACH. Resident 75's diagnoses included but was not limited to right intertrochanteric femur (located in the thigh bone close to the hip) fracture, unspecified dementia without behavioral disturbance, history of falling, and sacral (tail bone) stage 4 pressure ulcer (bed sore with full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). A review of the minimum data set (MDS, a comprehensive care planning tool), dated 2/25/20, indicated Resident 75 was moderately impaired for daily decision making. The MDS indicated Resident 75 did not have any functional ROM limitations in both legs. A review of Resident 75's MDS, dated [DATE], 8/20/20, 11/20/20, and 2/18/21, indicated both legs had functional ROM limitations. A review of the Rehabilitation Functional ROM (range of motion) and Voluntary Movement Screen, dated 2/15/20, indicated Resident 75 had no ROM limitations in both legs. During an observation on 5/3/21, at 12:40 pm, in Resident 75's room, Resident 75 was lying in bed. Resident 75's right leg crossed midline over the left leg and dangled over the left side of the bed. Resident 75's left leg was crossed underneath the right leg with the left hip positioned in external rotation (hip rotated away from the body) and knee bent. Resident 75's left leg position resembled sitting on the floor with legs crossed in front of the body. Resident 75 complained of left leg pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/4/21, at 2:49 p., Certified Nursing Assistant 6 (CNA 6) stated the Resident 75's legs were always crossed. During an interview on 5/7/21, at 1:31 pm, MDS Coordinator (MDS 1) stated that all current care plans should be in the clinical record. MDS 1 reviewed Resident 75's MDS assessments dated 2/25/20 and 5/21/20. MDS 1 stated Resident 75 had a significant decline in range of motion to both legs on the 5/21/20 MDS assessment. MDS 1 stated Resident 75's clinical record did not have any care plans to address the decline in range of motion to both legs. MDS 1 stated that the care plan should have been completed since Resident 75 was under the facility's care. A review of the facility's policy entitled, Care Plans - Comprehensive revised September 2010, indicated that Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. 44027 f. A review of Resident 133's Face Sheet indicated the facility admitted the resident on 3/19/2021 with diagnoses of anxiety disorder (a mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities). During a review of Resident 133's Anxiety care plan dated 3/31/2021 indicated restlessness, as a behavior of anxiety and the interventions were to encourage activities of choice. During an observation and interview on 5/7/2021 at 10 am Resident 133 was calm sitting in a wheelchair calm and stated she slept well. During an interview on 5/7/2021 at 11:51am, LVN 6 stated Resident 133's Patient Care Plan for Anxiety did not describe the resident's behaviors of restlessness (feeling the need to constantly move). LVN 6 could not describe or give an example of how resident 133 exhibited restlessness. 44037 g. A review of Resident 91's Face Sheet indicated the facility admitted Resident 91 on 3/25/2014 and readmitted the resident on 11/8/2019 with diagnosis of dementia (gradual decrease in memory and cognition [ability to think and reason that affect a person's daily functioning). A review of Resident 91's MDS dated [DATE], indicated Resident 91 had minimal difficulty with hearing, and had clear speech and capable of expressing ideas and wants. A review of Resident 91's Physicians Order dated 5/2021, indicated Resident 91 could have an audiology consult (a specialized in assessment of hearing) and follow up as needed (PRN). During an interview and observation on 5/3/2021 at 1:25 pm, Resident 91 pointed to her ear and stated she was hard of hearing. Resident 91's speech volume high when speaking. Resident 91 informed the surveyor to speak louder and closer. Resident 91 stated she did not own a hearing device. During Interview on 5/3/2021 at 1:47 pm, LVN 4 stated Resident 91 did not have hearing aids. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 5/4/2021 at 11:41 am, FAM 2A stated Resident 91 had history of having a lot of earwax which was removed at a hospital. FML 2A stated extensive amount of earwax was removed from each ear. During a record review and concurrent interview on 5/7/2021 at 12:22 pm the MDS Nurse 3, stated Resident 91 was assessed with minimal difficulty with hearing and a care plan was not developed to address the interventions for hearing difficulties. MDS Nurse 3 stated Resident 91 should have been referred to social services for audiology or ENT (Ear, Nose and Throat specialist) for evaluation. 44635 h. A review of Resident 146's Face Sheet (an admission record), indicated the facility admitted the resident on 3/23/21 with diagnoses of chronic respiratory failure (a condition that results in the inability to effectively exchange carbon dioxide and oxygen) and dependence on ventilator (a machine that provides mechanical ventilation by moving breathable air into and out of the lungs). A review of Resident 146's Psychotropic Assessment, dated 3/24/21, indicated the resident has diagnoses of mental illness as psychosis (A mental disorder characterized by a disconnection from reality). A review of Resident 146's History and Physical Examination, dated 3/24/21, indicated the resident was admitted with tracheostomy tube (a tube inserted in the neck below the vocal cords for breathing) and percutaneous endoscopic gastrostomy tube (PEG, a flexible feeding tube placed into the stomach). A review of Resident 146's MDS, dated [DATE], indicated resident had severe impairment for decision making and required extensive assistance for activities in daily living (ADL, such as dressing, toilet use and personal hygiene) as well as one-person assist for bed mobility, and two-person assist for transfer. A review of Resident 146's medical record, titled Patient Care Plan: Psychotropic Medication, dated 3/23/21, the plan of care did not include Ativan and did not include non-pharmacological approached intervention to address the behavior of tube pulling. A review of Resident 146's Physician Orders, dated May 2021, indicated an order for the resident to receive Ativan 0.5 mg every six hours as needed for anxiety as manifested by pulling of medical equipment or tubing for a period of 14 days. During an observation on 5/3/21, at 10:45 p.m., Resident 146 was lying in bed with eyes closed and with calm and even breathing. i. A review of Resident 163's Face Sheet, undated, indicated the facility admitted the resident on 3/31/21 with diagnoses of Candida sepsis (a body's extreme response to a fungal infection), urinary tract infection (an infection in urinary system), pneumonia (an infection in one or both lungs), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). (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 163's Physician Orders, dated May 2021, indicated an order for the resident to receive Ritalin 5 mg twice a day, starting on 3/31/21. A review of Resident 163's MDS, dated [DATE], indicated the resident had severe impairment for decision making and was totally dependent on staff for activities of daily living as well as requiring one-person assist for bed mobility and transfer. During an observation on 5/3/21, at 11:48 a.m., Resident 163 was sleeping with no distress. During an interview on 5/7/21 at 8:42 a.m., Registered Nurse 4 (RN 4) stated an individualized care plan was not initiated for the use of Ritalin. RN 4 also stated that a care plan must be done for psychotropic medications according to the facility's policy. A review of Resident 163's Multi-IDT (interdisciplinary team) Conference, undated, indicated that the resident's medication regimen was not discussed. A review of the facility's policy and procedure titled Care Planning - Interdisciplinary Team, dated December 2016, indicated a comprehensive, person-centered care plan that include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. A review of a publication on www.ncbi.nlm.nih.gov/books/NBK482451/?report=printable, indicated off-label use of Ritalin for treatment of depression in the elderly population.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 33670 Based on observation, interview, and record interview, the facility failed to provide assistance with communication for one of one sampled resident (Resident 187). This deficient practice had the potential for Resident 187 not to communicate effectively. Findings: A review of Resident 187's Face Sheet (admission record) indicated the facility admitted Resident 187 on 1/31/2012 and readmitted the resident on 11/17/2019 with diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). A review of Resident 187's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 1/11/2021, indicated Resident 187 was unable to speak, and was severely impaired in cognitive skills for daily decision making. During an observation on 5/4/2021 at 10:41 am, Resident 187 was awake nonverbal and made an incomprehensible sound. During an interview and concurrent observation on 5/4/2021 at 11:10 am Licensed Vocational Nurse 17 (LVN 17) stated there was no communication board or device. LVN 17 stated Resident 187 could benefit from a communication board with a picture. During an interview on 5/4/2021 at 11:25 am, Certified Nursing Assistant Nurse 5 (CNA 5) stated Resident 187 was nonverbal and spoke a foreign language which she could not speak. CNA 5 stated it would help if Resident 187 had a communication tool at the bedside. A review of the facility's Quality of Life-Accommodation of Needs policy and procedure with a revised date of August 2009, indicated the resident's individual needs and preferences should be accommodated to the extent possible.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 28074 Based on observation, interview, and record review, the facility failed to evaluate Resident 75's treatment for skin rash. This deficient practice had the potential for Resident 75 not to receive the appropriate care and treatment and inadequate monitoring of the resident's progress and changes in condition. Findings: A review of Resident 75's Face Sheet (Admission Record) indicated the facility admitted Resident 75 on 4/19/2019 and readmitted the resident on 11/15/2019 from a general acute care hospital (GACH) with diagnoses of right intertrochanteric femur fracture (broken hip), dementia (loss of memory and other mental abilities severe enough to interfere with daily life), and history of falling A review of Resident 75's Minimum Data Set (MDS, a comprehensive care planning tool), dated 2/18/2021, indicated Resident 75 was totally dependent for eating and required one person to assist. During an observation on 5/3/2021 at 9 am, Resident 75 was lying in bed and was scratching her upper body, both arms and neck. On closer observation, resident was observed with multiple raised bumps on her back and font body, both arms, neck and shoulder. A review of Resident 75's physicians order dated 4/13/2021, indicated for the resident to receive Naftifine HCL 2 % cream (medication to treat skin conditions) to apply to affected areas, bilateral (both) thighs and bilateral arms two times a day (BID) for 4 weeks for contact dermatitis (a condition that makes skin red or inflamed). The physician orders indicated for the resident to receive Flucinonide 0.1 % cream (medication used to treat a variety of skin conditions), apply to affected areas, bilateral thighs and bilateral arms twice a day for 4 weeks. During an interview and a review of Resident 75's medical record on 5/3/2021, at 9:30 am, Licensed Vocational Nurse 7 (LVN 7) stated Resident 7 had been receiving the cream for the skin rashes since 4/13/2021 and stated there was no documented evidence that there was an evaluation if the treatment was effective. A review of the facility's Care Plans-Comprehensive facility's policy and procedure, dated 9/2010, indicated, the care planning interdisciplinary team was responsible for the review and updating the resident's plan of care.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33670 Based on observation, interview and record review, the facility failed to assist three of three sampled residents (Residents 27, 91 and 187) with proper treatment and assistive device to improve hearing abilities. The residents were not referred to the physician to assess the cause of and treatment for hearing impairment. This deficient practice had resulted in Residents 27, 91 and 187 not able to hear staff effectively during care and had the potential to result in miscommunication about their healthcare plans that could result in decline in the quality of care and life. Findings: a. A review of Resident 27's Face Sheet (admission record), indicated the resident was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heart beat) and neuralgia (an intense, typically intermittent pain along the course of a nerve, especially in the head or face). A review of the Minimum Data Set (MDS, a resident assessment and care screening tool), dated 2/2/21, indicated Resident 27 had no impairment in cognitive skills for daily decision making and required total assistance with one person on toilet use and limited assistance with personal hygiene. The MDS indicated Resident 27 had limited range of motion on both lower extremities. During an observation and interview on 05/6/21 at 9:56 AM, Resident 27 was spoke loudly when answering questions. Resident 27 asked if the surveyor could speak closer to her right ear because she could not hear and she does not have hearing aid devices. During an interview on 05/6/21 at 10:02 AM, Resident 27 stated she does not have a hearing aid device and she usually spoke loud due to her hearing difficulties. During an interview and concurrent record review on 05/07/21 8:05 AM. MDS Nurse 4 stated Resident 27 had hard of hearing. MDS Nurse 4 stated there were no interventions to assist the resident with the hearing difficulty or obtaining hearing aid devices. During an interview on 05/07/21 8:45 AM, Certified Nursing Assistant 5 (CNA 5) stated she observed Resident 27 with a hearing difficulty for at least three years and she had not seen the resident use hearing aid devices. During an interview on 5/7/21 at 9:55 a.m. MDS Nurse 1 stated she spoke to Resident 27's responsible party who informed her that the resident had chronic problem with earwax and was seen by the ENT (a medical specialty in Ears, Nose and Throat) physician in the past. During an interview and concurrent record review, the Social Service Designee 2 (SSD 2) stated there was no documented evidence Resident 27 was referred to the ENT for ear check up. SSD 2 stated Resident 27's hearing issue was not discussed during the care planning meeting to help the resident obtain hearing aid devices. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. A review of Resident 187's Face Sheet, indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). A review of the MDS, dated [DATE], indicated Resident 187 unable to speak, rarely make self understood, sometimes understood others and severely impaired in cognitive skills for daily decision making. During an observation on 5/4/21 at 10:41 AM, Resident 187 was awake, non verbal and positioned with both hands closed to his chest and guarding. A concurrent interview was conducted; Resident 187 started to make a weak incomprehensible sound. During an interview and concurrent observation on 5/4/21 at 11:10 AM, Licensed Vocational Nurse 17 (LVN 17) stated Resident 187 had hard of hearing and does not have a hearing device. LVN 17 stated she often talks to the resident loudly. A review of Resident 187's clinical records including the nursing notes, physician record and consults notes indicated, Resident 187 had not been assessed or treated for the resident's hearing issue. 44037 c. A review of Resident 91's Face Sheet, indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (gradual decrease in memory and cognition [ability to think and reason that affect a person's daily functioning) without behavioral disturbances and major depressive disorder (persistent feeling of sadness and loss of interest). A review of the MDS, dated [DATE], indicated Resident 91 has minimal difficulty with hearing, has clear speech, capable of expressing ideas and wants and understand others. During an observation on 5/3/21 at 1:25 PM, Resident 91 had hard of hearing and spoke loudly. A concurrent interview was conducted; Resident 91 stated, Speak up, I cannot hear!. Resident 91, stated she does not own a hearing aid device. During an interview on 05/03/21 at 1:47 PM, LVN 4 stated Resident 91 had no hearing aid device in her personal property and she had to speak loudly to communicate with Resident 91. A review of Resident 91's Physicians Order, dated 11/08/2019 and recapitulated (summarized) order for the month of 5/2021, indicated Resident 91 may have audiology consult (a specialized in assessment of hearing) and follow up PRN (as needed). During a review of Resident 91's clinical record indicated, Resident 91 had no plan of care to address the resident's hearing difficult. During a concurrent interview and record review on 5/4/21 at 11:41 AM, MDS Nurse 3 stated Resident 91 should have been referred to Social Services for Audiology (study for hearing)/or ENT (Ear, Nose and/or Throat) evaluation as MDS indicated Resident 91 had minimal difficulty with hearing on 2/26/21.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28074 Based on observation, interview and record review the facility failed to provide care and services for 7 of 11 sampled residents (Residents 75, 136, 146, 163, 650, 653, and 103) with or at high risk for developing pressure injuries (area of damaged skin caused by staying in one position for too long) as indicated in the physician's order, plan of care and policy and procedures by failing to:. 1. For Resident 75, the staff did not apply a heal protector (devices that reduces pressure on bony areas) and did not reposition the resident at least every two hours. 2. For Resident 146 who had a stage 4 pressure ulcer (injury to the skin and underlying tissue, primarily caused by prolonged pressure on the skin), was not repositioned every two hours. 3. For Resident 163, who had a pressure injury Stage 3 (full thickness tissue loss, subcutaneous [under the skin] fat may be visible but bone, tendon or muscle are not exposed), was not repositioned every two hours. 4. For Resident 650 who was at risk for developing pressure injuries was not repositioned every two hours. 5. Resident 653 who was at risk for developing pressure injuries was not repositioned every two hours. 6. Resident 103 who had a sacral coccyx (tail bone) unstageable pressure (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough [a mass of dead tissue separating from an ulcer] or eschar [dead tissue]).injury was not repositioned every two hours. 7. For Resident 136 who had a Stage 3 pressure injury, was not repositioned every two hours and the low air loss mattress (LAL mattress which operates using a blower based pump that was designed to circulate a constant flow of air), was not set according to the resident's weight to best relieve pressure. [NAME] These deficient practices had the potential to result in the development of new and or worsened pressure injuries. Findings: 1. A review of Resident 75's Face Sheet (Admission Record) indicated the facility admitted Resident 75 on 4/19/2019 and readmitted the resident on 11/15/2019 from a general acute care hospital (GACH) with diagnoses of right intertrochanteric femur fracture (broken hip), dementia (loss of memory and other mental abilities severe enough to interfere with daily life), and history of falling. A review of Resident 75's Minimum Data Set (MDS, a comprehensive care planning tool), dated 2/18/2021, indicated Resident 75 was non-ambulatory, incontinent of bowel and bladder, and required total assistance with all activities of daily living. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 75's physician's order dated 4/25/2021, indicated Resident 75 had sacrococcyx (tail bone) pressure injury (unidentified Stage) and to provide the resident with heel protectors. A review of Resident 75's Risk for Skin Breakdown care plan dated 2/18/2021, indicated the resident was at risk for further skin breakdown and the plan was to reposition the resident at least every two hours. During an observation on 5/3/2021 at 9 am, Resident 75 was observed lying on her back on a low air loss mattress (LAL-a mattress that provides a flow of air to assist in managing the heat and humidity of the skin). During observations on 5/3/2021, at 12:59 pm, and at 2:30 pm, Resident 75 was observed lying on her back in bed with both feet resting directly on the bed. During observation on 5/4/2021, Resident 75 was observed lying on her back while in bed at 7:14 am, 9:09 am, 9:50 am, 10:02 am, and 1:40 pm without heel protectors on her feet. During an interview on 5/4/2021, at 2:50 pm, Certified Nursing Assistant 6 (CNA) 6 stated Resident 75 had wounds to her back. CNA 6 stated Resident 75 always would be on her back. During an interview on 5/4/2021, at 3 pm, CNA 6 and Licensed Vocational Nurse 7 (LVN 7), CNA 6 stated that she was not aware Resident 75 needed to wear heel protectors and that she had been using the pillows. LVN 7 stated there should have been heel protectors applied to help prevent the development of new pressure sores. LVN 7 stated the resident should have been turned and monitor her positioning every two hours. A review of the facility's Pressure Ulcer Risk Assessment, policy and procedure with a revised date of 9/13, indicated, The most common site of a pressure ulcer is where the bone is near the surface of the body including the back of head around the ears, elbows, shoulder blades, backbones, hips, knees, heels, ankles and toes. A review of the facility's Repositioning, policy and procedure, with a revised date of 5/13, indicated to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. 44635 2. A review of Resident 146's Face Sheet (an admission record), indicated the facility admitted the resident on 3/23/2021 with diagnosis of chronic respiratory failure (a condition that results in the inability to effectively exchange carbon dioxide and oxygen) and dependence on ventilator (a machine that provides mechanical ventilation by moving breathable air into and out of the lungs). A review of Resident 146's Resident Care Plan for alteration in skin integrity, dated 3/23/2021, indicated resident had an unstageable pressure injury, sacrococcyx (tailbone) pressure injury, and the plan of care was to turn and reposition at least every two hours and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 146's MDS dated [DATE], indicated the resident had severe impairment for decision making and required extensive assistance for activities in daily living (ADL, such as dressing, toilet use and personal hygiene) as well as one-person assist for bed mobility, and two-person assist for transfer. A review of Resident 146 Wound Assessment Report dated 4/26/2021, indicated the resident had a sacrococcyx wound debridement (medical removal of dead, damaged, or infected tissue to improve the healing) done by a wound consultant. The report also described the wound as an improved stage 4 pressure injury. A review of Resident ADL Flow Sheet (AFS), dated May 2021, did not indicate the frequency and time of repositioning. During an observation on 5/3/2021 at 10:48 am, Resident 146 was in a supine (lying face up) position with bent knees. During an observation on 5/3/21 at 1:05 pm, Resident 146 was in a supine position with eyes closed. During an observation on 5/3/21, at 2:26 pm, Resident 146 was in a supine position with bent knees and head of bed elevated to 45 degrees. During an observation on 5/5/21, at 8 am, Resident 146 was in a supine position with a pillow under both lower legs. During an interview on 5/5/21, at 3:31 pm, CNA 8 stated he documented repositioning in Resident 146's AFS but stated there was no place on it to chart a specific time of each repositioning. 3. A review of Resident 163's Face Sheet indicated the facility admitted the resident on 3/31/2021 with diagnosis of pneumonia (an infection in one or both lungs), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 163's Resident Care Plan for alteration in skin integrity, dated 4/1/2021, indicated assist the resident on turning or repositioning every two hours and as needed for comfort. A review of Resident 163's MDS dated [DATE], indicated the resident had severe impairment for decision making and was totally dependent on staff for activities of daily living (ADL, such as dressing, toilet use and personal hygiene), and required one-person assist for bed mobility and transfer. A review of Resident 163's Wound Assessment Report dated 4/26/21, indicated the resident had an improved stage 3 sacrococcyx pressure injury. A review of Resident 163's ADL Flow Sheet (AFS), dated May 2021, indicated no record of frequency or time of repositioning. During an observation on 5/3/2021 at 11:48 am, Resident 163 was resting with eyes closed in supine position. During an observation on 5/3/2021 at 2:35 pm, Resident 163 remained in supine position. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/3/2021 at 3:41 p.m., Resident 163 was in supine position. During an interview on 5/4/2021 at 1:30 pm, Registered Nurse 1 (RN 1),stated no one oversaw the monitoring of Resident 146 and 163 repositioning frequency. During an interview on 5/5/2021 at 3:32 pm, CNA 9 stated she was not sure about the time when Resident 163 was last repositioned. A review of the facility's policy and procedure titled, Repositioning, dated May 2013, indicated repositioning was critical for a resident who was immobile or dependent upon staff for repositioning. The policy indicated positioning the resident on an existing pressure ulcer should be avoided since it put additional pressure on tissue that was already compromised and may impede healing. The policy also indicated residents who were in bed should be on at least every two-hour repositioning schedule. 44290 4. During a review of Resident 650's care plan dated 4/13/2021 indicated Resident 650 had an unstageable pressure ulcer on the sacral coccyx (tail bone) and the plan of care was to turn and reposition resident at least every two hours and as needed. During an interview on 5/3/2021 at 2:58 pm, Resident 650 stated she had to ask the staff to reposition her. 5. During a record review of Resident 653's care plan dated 4/29/2021 indicated Resident 653 was at risk for skin breakdown and the plan of care was to reposition the resident at least every two hours. During an interview and concurrent observation on 5/4/2021, at 10:20 am Resident 653 was lying supine in bed and stated no one would assist in turning. During an observation on 5/4/2021 at 10:44 am Resident 653 was lying supine. During an observation on 5/4/2021 at 12:29 pm, Resident 653 was lying supine. During an observation on 5/4/2021 at 1:05 pm, Resident 653 was lying supine. During an interview on 5/6/2021 at 9:09 am with Resident 653 stated the staff would not assist her in turning every two hours or sooner. 6. During a review of Resident 103's Quadriplegia care plan dated 4/21/2021 indicated Resident 103 was at risk for skin breakdown and the plan was to reposition every two hours. During a review of Resident 103's MDS dated [DATE], indicated the resident was total dependent on staff for bed mobility. During a review of Resident 103's Activates of Daily Living (ADL) dated for the month of May 2021 did not indicate the time and position the resident was turned. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/4/2021 at 9:55am Resident 103 was supine in bed. During an interview on 5/4/2021 at 12:58 pm, Registered Nurse 2 (RN 2) stated the staff were supposed to reposition the residents. A review of the facility's policy and procedure titled Repositioning, dated May 2013, indicated residents who were in bed should be on at least an every two hour repositioning schedule. Documentation should be recorded in the resident's medical chart and include: 1. The position in which the resident was placed 2. The name and title of individual who gave the care 3. Any change in resident's condition 4. If the resident refused the care and why 5. Observations of anything unusual exhibited by resident 6. The signature and title of person recording data. 44037 7. A review of Resident 136's Face Sheet indicated the facility admitted Resident 136 on 10/02/2007 with diagnoses of stage 3 pressure injury and impairment of self-care. A review of Resident 136's MDS dated [DATE], indicated Resident 136 was totally dependent on staff for all activities of daily living such as bed mobility, transfer, locomotion, dressing, eating, toileting, personal hygiene, and bathing. MDS indicated Resident 136 was assessed as at risk for developing pressure sore. MDS indicated that Resident 136's skin and ulcer treatment included the use of pressure reducing device for bed. A review of Resident 136's care plan, titled Skin, dated 3/15/21, indicated Resident 136 was at risk for skin breakdown and the approach was to reposition the resident every two hours and to provide pressure reducing mattress. A review of Resident 136's physician order dated 5/2021, indicated for the resident to have a LAL mattress for wound management to be set according to resident's weight. During concurrent observation and interview on 5/4/2021 at 4:20 pm, LVN 14 stated Resident 136 was lying supine in bed. During observation on 5/6/2021 at 10 am Resident 136 was in a supine position. During observation on 5/6/2021 at 12 pm Resident 136 was in a supine position. During concurrent interview and record review on 5/6/2021 at 12:30 pm, LVN 14 stated Resident 136 needed to be repositioned. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/6/2021 at 3:09 pm, LVN 14 stated Resident 136 was in supine position and stated Resident 136 should be repositioned every two hours and stated the resident should be lying on the right side. During an observation, interview, and a review of Resident 136's medical record on 5/7/2021 at 1:55 pm LVN 15 and LVN 16 stated Resident 136 was 207 pounds. LVN 15 and LVN 16 stated Resident 136's LAL mattress settings was set as 250lbs and both stated the settings were not based on the resident's current weight.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to provide range of motion exercises (activity aimed at improving movement of a specific joint, a point where two bones make contact) to 11 of 12 sampled residents (Resident 75, 183, 91, 167, 146, 27, 136, 163, 151, 40, and 103) as indicated in the facility's Rehabilitative (helping to restore to good condition) Nursing Care policy. This deficient practice resulted for Resident 75 to experience pain and decline in mobility that caused severe contractures (deformity and joint stiffness) of the resident's right hand and both legs. Findings: Cross reference F656, F686, and F725 a. A review of Resident 75's Face Sheet (Admission Record) indicated the facility admitted Resident 75 on 4/19/2019 and readmitted the resident on 11/15/2019 from a general acute care hospital (GACH) with diagnoses of right intertrochanteric femur fracture (broken hip), dementia (loss of memory and other mental abilities severe enough to interfere with daily life), and history of falling A review of Resident 75's Occupational Therapy (OT, profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]), Evaluation and Plan of Treatment, dated 11/16/2019, indicated Resident 75's right arm range of motion (ROM, the full movement potential of a joint) was within normal limits (normal joint movement). The OT Evaluation document indicated Resident 75's left arm ROM was within functional limits (sufficient joint movement to functionally complete daily routines) and the resident's left shoulder had limited motion. A review of Resident 75's Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 11/16/2019, indicated Resident 75's ROM in both legs were within functional limits. A review of Resident 75's Rehabilitation Functional ROM and Voluntary Movement Screen, dated 2/15/2020, indicated Resident 75 had no ROM limitations in both legs and both hands. A review of Resident 75's OT Discharge Summary, dated 2/22/2020, indicated Resident 75 was discharged with recommendations for a Restorative Range of Motion Program (to restore as much independence as possible and/or prevent decline in function) for both arms. A review of Resident 75's PT Discharge Summary, dated 2/22/2020, indicated a Restorative Program was not indicated for Resident 75's legs because Resident 75 was transferred to hospice care (care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure). (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 75's Physician's Orders, dated 2/22/2020, indicated for the resident to receive Restorative Nursing Assistant (RNA, nursing aide program that helps residents maintain their function and joint mobility) services and to provide Resident 75 with passive range of motion (PROM, amount of motion at a given joint when the joint is moved by an external force or by a therapist) exercises on both arms five days a week as tolerated by the resident. During an interview on 5/4/2021, at 8:42 a.m., Director of Rehabilitation (DOR) stated therapists provided education to RNA staff prior to transitioning residents to RNA services. A review of Resident 75's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 2/25/2020 indicated Resident 75 was moderately impaired with cognitive (thinking and memory) skills for daily decision making. The MDS indicated Resident 75 had clear speech, usually expressed ideas and wants, and understood others. The MDS indicated Resident 75 did not have any limitations in functional ROM in both arms and legs. A review of Resident 75's care plan titled, Activities of Daily Living Deficit, dated 2/25/2021, indicated the interventions were to provide ROM exercises to the resident. A review of Resident 75's RNA Flow Sheets indicated Resident 75 received range of motion exercises to both arms in 2/2020 and 4/2020. A review of Resident 75's Physician's Orders dated 9/18/2020 indicated to discontinue Resident 75's RNA program. A review of Resident 75's Joint Mobility Assessment, dated 5/14/2020, 8/12/2020, and 11/11/2020, indicated minimum loss of ROM (25-50%) on Resident 75's right hip and right knee and moderate loss of motion (60-75%) on the left shoulder. A review of Resident 75's Joint Mobility Assessment, dated 2/20/2021, indicated the resident had moderate loss of ROM on Resident 75's left shoulder, both hips and both ankles. The Joint Mobility Assessment indicated Resident 75 had severe loss of motion (75-100%) on Resident 75's right hand, right fingers, and right knee. During an observation on 5/3/2021 at 12:40 pm, inside Resident 75's room, Resident 75 was lying in bed. Resident 75's right leg crossed midline over the left leg and dangled over the left side of the bed. Resident 75's left leg was crossed underneath the right leg with the left hip positioned in external rotation (hip rotated away from the body) and knee bent. Resident 75's left leg position resembled sitting on the floor with legs crossed in front of the body. Resident 75 complained of left leg pain. During an interview on 5/4/2021 at 2:49 pm, Certified Nursing Assistant 6 (CNA 6) stated the Resident 75's legs were always crossed. During an interview on 5/5/2021 at 8:53 am, Licensed Vocational Nurse 8 (LVN 8) stated both of Resident 75's legs were contracted (deformed with joint stiffness). LVN 8 stated it was difficult to turn the resident to either side since Resident 75 screamed from discomfort. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/6/2021, at 11:59 am, MDS Nurse 2 (MDS 2) stated if there was no RNA Flow Sheet in the clinical record, then the resident was not seen for RNA exercises. During an interview on 5/6/2021, at 3:54 p.m., Occupational Therapist 1 (OT 1) stated Resident 75 was able to sit in a wheelchair for activities of daily living, like hygiene, grooming, and lower body dressing. OT 1 stated that she recommended a Restorative Nursing Program for Resident 75 to maintain ROM to both arms since Resident 75 was a long-term care resident with limited cognition, making Resident 75 at risk for developing contractures. During an interview on 5/6/2021, at 4:24 p.m., the facility's Director of Nursing (DON) stated residents on hospice care such as Resident 75, should continue to receive basic nursing care while residing in the facility, which included but was not limited to hygiene, feeding, activities, medication administration, and mobility. During an observation on 5/7/2021, at 7:55 am, in Resident 75's room, Resident 75 was eating using the left hand to hold onto a bowl while the right-hand thumb and index finger held the utensil. Resident 75's right-hand middle, ring, and small fingers were observed in a flexed position. During an observation and concurrent interview on 5/7/2021, at 7:59 am, in Resident 75's room, LVN 8 was unable to extend Resident 75's right hand middle, ring, and small fingers which were in a flexed (bent) position touching the right palm. Resident 75 expressed pain upon LVN 8's attempts to extend the fingers. LVN 8 then repositioned Resident 75's legs. Resident 75 became tearful and stated that the left leg was painful. LVN 8 stated Resident 75 did not like to be turned due to the contractures in both legs. During an interview on 5/7/2021, at 9:57 am, Director of Rehabilitation (DOR) stated Resident 75's ROM further declined on 2/20/2021 as compared to the assessment on 11/11/2020. During an interview on 5/7/2021, at 10:58 am, the DON stated restorative nursing care was a continuation of nursing care for residents to maintain mobility and maximize function. DON stated restorative nursing care did not exclude hospice residents. DON stated Resident 75's contractures were avoidable as the facility failed to provide any restorative nursing care for range of motion. During an interview on 5/7/2021, at 12:05 pm, Medical Records 2 (MR 2) stated she was unable to locate Resident 75's RNA Flow Sheets for PROM exercises on both arms for 3/2020, 5/2020, 6/2020, 7/2020, 8/2020 and 9/2020. A review of the facility's policy titled, Rehabilitative Nursing Care, with a revised date of 7/2013, indicated the facility's rehabilitation nursing care program was designed to assist each resident to achieve and maintain an optimal level of self-care and independence. The policy indicated the program included assisting residents to carry out prescribed therapy exercises. b. A review of Resident 183's Face Sheet indicated Resident 183 was readmitted to the facility on [DATE]. Resident 183's diagnoses included were chronic respiratory failure (airways carrying air to lungs become narrow and damaged, limiting air movement in the body), pressure ulcer (bed sore) of right buttock, left hip, sacral (tail bone) region, right heel, and left heel, and attention to tracheostomy (hole that surgeons make through the front of the neck and into the windpipe (trachea) to allow air into the lungs). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 183's MDS, dated [DATE], indicated Resident 183's cognition was intact. Resident 183 required total assistance with bed mobility, transfers, dressing, and hygiene. The MDS indicated Resident 183 had functional ROM limitations on both arm and both legs. A review of Resident 183's Physician's Orders, dated 6/30/20, indicated for RNA to provide gentle PROM on both arms and legs, five times per week or as tolerated. It also indicated to apply bilateral (both sides) ankle foot orthosis (AFO, brace to hold the foot and ankle in the correct position) for both legs, five times per week for four to six hours or as tolerated. A review of Resident 183's Restorative Record, dated 4/2021, indicated the following dates with an X and blank dates: 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/10/21, 4/11/21, 4/17/21, 4/18/21, 4/20/21, 4/23/21, 4/24/21, 4/25/21, 4/29/21, and 4/30/21. During an interview on 5/4/21, at 8:42 am, RNA 1 stated a blank date in a resident's Restorative Record indicated the resident was not seen that day for RNA. During an interview on 5/6/21 at 12:24 pm, RNA 4 stated an X on the Restorative Record indicated the resident was not seen for RNA services on that specific date or dates. During an interview on 5/6/21 at 12:50 pm, MDS 2 stated Resident 183 was not seen for RNA per physician's order on 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/10/21, 4/11/21, 4/17/21, 4/18/21, 4/20/21, 4/23/21, 4/24/21, 4/25/21, 4/29/21, and 4/30/21 since the RNA staff were pulled to perform Certified Nursing Assistant duties. MDS 2 stated residents could develop contractures without the provision of RNA services. c. A review of Resident 91's Face Sheet indicated Resident 91 was readmitted to the facility on [DATE]. Resident 91's diagnoses included were chronic respiratory failure heart failure (), and muscle wasting. A review of Resident 91's MDS, dated [DATE], indicated Resident 91's cognition was intact. Resident 91 required extensive assistance with bed mobility, transfers, and hygiene. The MDS indicated Resident 91 had functional ROM limitations on both arms and both legs. A review of Resident 91's Physician's Orders, dated 12/21/20, indicated for RNA to provide active assistive range of motion (AAROM, movement of a joint of limb in which the person provides some effort but also receives some assistance from an outside force) exercises on both legs, five days per week or as tolerated. A review of Resident 91's Physician's Orders, dated 2/25/20, indicated for RNA to provide AAROM exercises on both arms, five days per week or as tolerated. During an observation on 5/6/21 at 9:10 am, Resident 91 moved both arms, but complained of left shoulder pain. During an interview on 5/6/21, at 9:33 am, RNA 3 stated a blank date in a resident's Restorative Record indicated the resident was not seen for RNA. RNA stated Resident 91 needs to be medicated prior to RNA exercises. RNA 3 stated Resident 91 can develop contractures and further pain if not seen for RNA exercises. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 91's Restorative Record for 4/2021 indicated the following blank dates: 4/1/21, 4/2/21, 4/3/21, 4/4/21, 4/5/21, 4/7/21, 4/8/21, 4/9/21, 4/13/21, 4/14/21, 4/25/21, 4/26/21, 4/27/21, and 4/30/21. A review of Resident 91's Restorative Record for 5/2021 indicated the following blank dates: 5/1/21, 5/2/21, and 5/4/21. During an interview on 5/6/21, at 9:33 am, RNA 3 stated Resident 91 was not seen on 5/4/21 since it was RNA 3's day off. In a follow-up interview on 5/6/21 at 10:02 am, RNA 3 stated Resident 91 was not seen per physician's orders in 4/2021 due to staffing shortage. RNA 3 stated that RNA staff were pulled to perform Certified Nursing Assistant duties. d. A review of Resident 167's Face Sheet indicated Resident 167 was readmitted to the facility on [DATE]. Resident 167's diagnoses included were hemiplegia (weakness on one side of the body) following a cerebral infarct (damage to tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant side. A review of Resident 167's MDS, dated [DATE], indicated Resident 167's cognition was intact. Resident 167 required limited assistance with bed mobility and transfers, and required extensive assistance with dressing. The MDS indicated Resident 167 had functional ROM limitations on one arm. A review of Resident 167's Physician's Orders, dated 4/13/21, indicated for RNA to provide PROM exercises on left arm, five days per week as tolerated and to apply and remove left hand splint (material used to restrict, protect, or immobilize a part of the body to support function, assist, and/or increase range of motion) for 4-6 hours, five days per week as tolerated. A review of Resident 167's Physician's Orders, dated 4/19/21, indicated for RNA to provide ambulation (walking) using hemi-walker (small, one-handed walker intended to be used for residents whose one half of their body is weakened), five days per week as tolerated. During an observation and interview on 5/3/21, at 10:35 am, Resident 167 was observed with left sided weakness and was not wearing a splint. stated Resident 167 was supposed to receive ROM exercises and wear a splint to the left arm. Resident 167 denied receiving any ROM exercises and stated the splint was not applied. A review of Resident 167's Restorative Record for April 2021 was completely blank. During an interview on 5/6/21, at 9:33 a.m., RNA 3 stated that a blank date in a resident's Restorative Record indicated that the resident was not seen that day for RNA. During an interview on 5/6/21, at 11:59 a.m., MDS 2 stated Resident 167 was not seen for RNA per physician's order since the RNA staff were pulled to perform Certified Nursing Assistant duties in 4/2021. MDS 2 stated residents could develop contractures without the provision of RNA services. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	e. A review of Resident 146's Face Sheet indicated Resident 146 was admitted to the facility on [DATE]. Resident 146's diagnoses included but was not limited to chronic respiratory failure (airways carrying air to lungs become narrow and damaged, limiting air movement in the body), heart valve replacement, muscle wasting, and attention to tracheostomy (hole that surgeons make through the front of the neck and into the windpipe [trachea] to allow air into the lungs). A review of Resident 146's MDS, dated [DATE], indicated Resident 146 was severely impaired with daily decision making, required extensive assistance with bed mobility and dressing, and required total assistance with transfers and eating. The MDS indicated Resident 146 had functional range of motion (ROM) limitations in one arm and one leg. A review of Resident 146's Physician's Orders, dated 4/28/21, indicated for RNA to provide gentle PROM on both legs, five days per week or as tolerated, and PROM on both arms, five days per week or as tolerated. During an interview on 5/6/21, at 11:59 a.m., MDS 2 stated was unable to locate Resident 146's Restorative Record for April and May 2021. MDS 2 stated Resident 146 was not seen for RNA exercises since 4/29/21. f. A review of Resident 27's Face Sheet indicated Resident 27 was admitted to the facility on [DATE]. Resident 27's diagnoses included but was not limited to spinal stenosis (narrowing) in the lumbar (lower back) region. A review of Resident 27's MDS, dated [DATE], indicated Resident 27's cognition was intact, was independent with eating, and required limited assistance for dressing. The MDS indicated Resident 27 had functional range of motion limitations in both legs. During an observation and interview on 5/3/21, at 11:30 a.m., Resident 27 was observed with contractures to both legs. Resident 27 stated Resident 27 was supposed to receive range of motion exercises three times per week. Resident 27 denied receiving exercises. A review of Resident 27's Physician's Orders, dated 3/9/17, indicated for RNA to provide active assisted range of motion (AAROM, movement of a joint of limb in which the person provides some effort but also receives some assistance from an outside force) to both arms, 3 times per week and PROM to both legs, 3 times per week. Further review of Resident 27's Physician's Orders, dated 10/17/19, indicated for RNA to apply both ankle foot orthoses (AFO - brace to hold the foot and ankle in the correct position), 3 times for week for 4-6 hours or as tolerated. During an interview on 5/6/21, at 9:33 a.m., RNA 3 stated that a blank date in a resident's Restorative Record indicated that the resident was not seen that day for RNA. A review of Resident 27's Restorative Record for April 2021 indicated blank dates on 4/1/21, 4/2/21, 4/3/21, 4/4/21, 4/5/21, 4/6/21, and 4/7/21. During an interview on 5/6/21, at 11:59 a.m., MDS 2 stated Resident 27 was not seen for RNA per physician's order since the RNA staff were pulled to perform Certified Nursing Assistant duties in April 2021. MDS 2 stated residents could develop contractures without the provision of RNA services. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	g. A review of Resident 136's Face Sheet indicated Resident 136 was admitted to the facility on [DATE] with diagnoses including but not limited to heart disease, morbid (severe) obesity, and chronic embolism (blot clot). A review of Resident 136's MDS, dated [DATE], indicated Resident 136 was moderately impaired for daily decision making and required total assistance for bed mobility, transfers, dressing, hygiene, and eating. During an observation on 5/3/21 at 10:26 a.m., Resident 136 was lying in bed with the right arm positioned into shoulder internal rotation (rotated toward the body), elbow bent, wrist bent down, and fingers bent at the knuckles. Resident 136 was not wearing a splint (material used to restrict, protect, or immobilize a part of the body to support function, assist, and/or increase range of motion) on the right arm. A review of Resident 136's Physician's Orders indicated for RNA to provide the following: - 10/16/19: PROM to both legs, five times per week as tolerated. - 10/17/19: PROM to the right arm, five times per week as tolerated. - 2/3/20: RNA to apply right elbow splint, five times per week for 4-6 hours or as tolerated. - 12/19/20: PROM exercises to right arm, five times per week as tolerated. - 12/19/20: Apply right elbow splint for 4-6 hours, five times per week as tolerated. - 12/21/20: Gentle PROM on right leg, five times per week or as tolerated. - 12/21/20: Gentle active assistive range of motion (AAROM, movement of a joint of limb in which the person provides some effort but also receives some assistance from an outside force) on left leg, five times per week or as tolerated. During an interview on 5/4/21, at 9:25 am, RNA 2 stated there were 89 residents that received RNA services. During a follow-up interview on 5/4/21, at 10:59 a.m., RNA 2 stated Resident 136 was not seen for RNA on 5/3/21 since there was only one RNA staff. RNA 2 stated that residents could develop contractures and experience a decline in function without the provision of RNA services. During an interview on 5/6/21, at 9:33 a.m., RNA 3 stated that a blank date in a resident's Restorative Record indicated that the resident was not seen that day for RNA. A review of Resident 136's Restorative Record for April 2021 indicated the following blank dates: 4/1/21, 4/2/21, 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/7/21, 4/8/21, 4/9/21, 4/10/21, 4/12/21, 4/13/21, 4/14/21, 4/16/21, 4/18/21, 4/19/21, 4/20/21, 4/21/21, 4/22/21, 4/23/21, 4/24/21, 4/25/21, 4/26/21, 4/27/21, 4/29/21, and 4/30/21. During an interview on 5/6/21, at 11:59 a.m., MDS 2 stated residents were not seen for RNA per physician's order since the RNA staff were pulled to perform Certified Nursing Assistant duties in April 2021. MDS 2 stated residents could develop contractures without the provision of RNA services. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	h. A review of Resident 163's Face Sheet indicated Resident 163 was readmitted on [DATE] with diagnoses on pneumonia, heart failure, and pressure ulcer (bed sore) of the sacral (tail bone) region. A review of Resident 163's MDS, dated [DATE] indicated Resident 163 was severely impaired for daily decision making and required total assistance for bed mobility, transfers, dressing, and hygiene. The MDS indicated Resident 163 had functional range of motion limitations in both arms and both legs. A review of Resident 163's Physician's Orders, dated 4/27/21, indicated for RNA to provide PROM to both legs, five days per week as tolerated. Resident 163's Physician's Orders, dated 4/27/21 also indicated for RNA to provide AAROM to both arms, five days per week as tolerated. During an interview on 5/4/21, at 9:25 am, RNA 2 stated there were 89 residents that received RNA services. During a follow-up interview on 5/4/21, at 10:59 a.m., RNA 2 stated residents in Stations 1 and 3, including Resident 163, were not seen for RNA on 5/3/21 since there was only one RNA staff. RNA 2 stated that residents could develop contractures and experience a decline in function without the provision of RNA services. A review of Resident 163's Restorative Record for May 2021 indicated the following blank dates: 5/1/21, 5/2/21, and 5/3/21. During an interview on 5/6/21, at 9:33 a.m., RNA 3 stated that a blank date in a resident's Restorative Record indicated that the resident was not seen that day for RNA. i. A review of Resident 151's Face Sheet indicated Resident 151 was readmitted to the facility on [DATE] with diagnoses including but not limited to Guillain-Barre syndrome (rare disorder in which the body's immune system attacks the nerves, eventually paralyzing the body) and chronic respiratory failure (airways carrying air to lungs become narrow and damaged, limiting air movement in the body). A review of Resident 151's MDS, dated [DATE], indicated Resident 151's cognition was intact but required total assistance for bed mobility, dressing, eating, and hygiene. The MDS indicated Resident 151 had functional limitations in range of motion in both legs. During an observation and interview on 5/3/21 at 10:30 a.m., Resident 151 was lying in bed and observed with weakness and contractures in both arms. Resident 151 denied receiving consistent range of motion exercises. A review of Resident 151's Physician's Orders, dated 1/16/21, indicated for RNA to provide PROM exercises in both arms, five days per week as tolerated, and PROM exercises in both legs, five days per week as tolerated. During an interview on 5/4/21, at 8:42 a.m., RNA 1 stated that a blank date in a resident's Restorative Record indicated that the During an interview on 5/4/21, at 8:42 a.m., RNA 1 stated that a blank date in a resident's Restorative Record indicated that the resident was not seen that day for RNA. RNA 1 stated there were 40 residents in the facility's subacute area that received RNA. RNA 1 was the only RNA staff on 5/3/21 and unable to perform RNA exercises with 24 subacute residents, including Resident 151. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/6/21 at 12:24 p.m., RNA 4 stated putting an X on the Restorative Records for the dates the resident was not seen for RNA. A review of Resident 151's Restorative Record for April 2021 indicated the following dates with an X and blank dates: 4/3/21, 4/4/21, 4/9/21, 4/10/21, 4/11/21, 4/12/21, 4/13/21, 4/16/21, 4/17/21, 4/18/21, 4/20/21, 4/21/21, 4/25/21, 4/27/21, and 4/28/21. A review of Resident 151's Restorative Record for May 2021 indicated the following dates with an X and blank dates: 5/1/21, 5/2/21, and 5/3/21. During an interview on 5/6/21, at 11:59 a.m., MDS 2 stated residents could develop contractures without the provision of RNA services. j. A review of Resident 40's Face Sheet indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including but not limited to chronic respiratory failure (airways carrying air to lungs become narrow and damaged, limiting air movement in the body), chronic kidney disease, and weakness. A review of Resident 40's MDS, dated [DATE], indicated Resident 40 cognition was moderately impaired for daily decision making and required total assistance for transfers, bed mobility, hygiene, dressing, and bathing. The MDS indicated Resident 40 had functional range of motion limitations in both legs. A review of Resident 40's Physician's Orders, dated 4/30/21, indicated for RNA to provide AROM to both arms, five days per week as tolerated. Further review of Resident 40's Physician's Orders, dated 5/4/21, indicated for RNA to provide AAROM to both legs, five days per week as tolerated. During an interview on 5/4/21 at 1:31 p.m., Resident 40 stated feeling stronger but needed more exercises. Resident 40 stated Resident 40 received exercises every three days for five minutes. During an interview on 5/4/21, at 8:42 a.m., RNA 1 stated that a blank date in a resident's Restorative Record indicated that the resident was not seen that day for RNA. RNA 1 stated there were 40 residents in the facility's subacute area that received RNA. RNA 1 was the only RNA staff on 5/3/21 was unable to perform RNA exercises 24 subacute residents, including Resident 40. A review of Resident 40's Restorative Record for May 2021 indicated the following blank dates for RNA to provide AROM to both arms: 5/1/21, 5/2/21, 5/3/21, 5/4/21, and 5/5/21. A review of Resident 40's Restorative Record for May 2021 indiated the following blank dates for RNA to provide AAROM to both legs: 5/4/21 and 5/5/21. k. A review of Resident 103's Face Sheet indicated Resident 103 was readmitted to the facility on [DATE] with diagnoses including but not limited to abscess (painful collection of pus, usually caused by a bacterial infection) of the right lower limb, hemiplegia (weakness on one side of the body) following cerebral infarct (damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, aphasia (difficulty communicating) following cerebral infarct, and dysphagia (difficulty swallowing). (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 103's MDS, dated [DATE], indicated Resident 103 was severely impaired for daily decision making and required total assistance for bed mobility, transfers, dressing, and bathing. The MDS indicated Resident 103 had functional range of motion limitations in both arms and both legs. A review of Resident 103's Physician Orders, dated 2/10/21, indicated for RNA to provide the following: - Both knee splints (material used to restrict, protect, or immobilize a part of the body to support function, assist, and/or increase range of motion), five times per week for 4-6 hours per day or as tolerated. - Gentle PROM on both arms, five times per week or as tolerated. - Right grip hand splint 4-6 hours per day, five times per week or as tolerated. - PROM to both legs, five times per week or as tolerated. - Apply right elbow extension split 4-6 hours per day, five times per week or as tolerated. During an interview on 5/4/21, at 9:25 am, RNA 2 stated there were 89 residents that received RNA services in the facility's skilled nursing area. During a follow-up interview on 5/4/21, at 10:59 a.m., RNA 2 stated residents in Stations 1 and 3, including Resident 103, were not seen for RNA on 5/3/21 since there was only one RNA staff. RNA 2 stated that residents could develop contractures and experience a decline in function without the provision of RNA services. During an interview on 5/6/21, at 9:33 a.m., RNA 3 stated that a blank date in a resident's Restorative Record indicated that the resident was not seen that day for RNA. A review of Resident 103's Restorative Record for April 2021 indicated the following blank dates: 4/1/21, 4/2/21, 4/4/21, 4/6/21, 4/7/21, 4/8/21, 4/9/21, 4/10/21, 4/11/21, 4/12/21, 4/13/21, 4/14/21, 4/17/21, 4/19/21, 4/20/21, 4/21/21, 4/22/21, 4/23/21, 4/25/21, 4/26/21, 4/29/21, and 4/30/21. A review of Resident 103's Restorative Record for May 2021 indicated the following blank dates: 5/1/21, 5/2/21, and 5/3/21. During an interview on 5/6/21, at 11:59 a.m., MDS 2 stated RNA staff were pulled to perform Certified Nursing Assistant duties in April 2021. MDS 2 stated residents could develop contractures without the provision of RNA services. A review of the facility's policy entitled, Rehabilitative Nursing Care revised July 2013, indicated that the facility's rehabilitation nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. The program included assisting residents to carry out prescribed therapy exercises.

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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** 33670 Based on observation, interview and record review, the facility failed to monitor, supervise and provide assistive device to prevent accidents and injuries for two of two sampled residents (Residents 649 and 174) by failing to: a. For Resident 649, the resident had recent history of fall and the pad alarm (a pad place on the bed that alarms when the person move off the bed) was found on the floor. b. For Resident 174, the resident had a physician's order to not give resident a straw due to the risk of aspiration (inhalation of food or fluids into the lungs) and the resident was observed to have a straw in her drink. These deficient practices had the potential to result in the aspiration for Resident 649 and fall with injury for Resident 174 that could lead to decline in the resident's well being of both residents. Findings: a. A review of Resident 649's Face Sheet (admission record), indicated the resident admitted to the facility on [DATE] with diagnoses that included left side hemiphlegia (paralysis to one side of the body) following cerebral infarction (also known as stroke or a brain damage due to lack of blood flow and oxygen to the brain). A review of the Minimum Data Set (MDS), a resident assessment and care screening tool, dated 4/19/21, indicated Resident 649 was able to express his ideas and wants and understands others. The MDS indicated Resident 649 required extensive assistance with one person assist on bed mobility and total assistance with transfer, toilet use and personal hygiene. A review of the plan of care, dated 4/12/21, indicated Resident 649 was at risk for fall related to Cerebrovascular attack (CVA, also known as stroke) and recent fall. The goal was to reduce the risk of fall for 90 days and the intervention was to provide assistive device and provide 1:1 sister. During an observation on 5/04/21 at 10:21 AM, Resident 649 was observed in the room undressed with sheets and clothing on floor. Resident 649 was sitting on the side of his bed with the bed alarm on the floor on the right side of his bed. During an interview on 5/04/21 at 10:41 AM, Licensed Vocational Nurse 9 (LVN 9) stated Resident 649 was at risk for fall and the physician ordered a tab alarm. LVN 9 stated Resident 649 had a tendency to get out of bed and take off his bed alarm. LVN 9 stated Resident 649's bed alarm need to be next to the resident at all times so it can alert staff when resident attempts to get out bed and prevent falls. (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 05/04/21 at 10:47 AM, CNA 7 stated Resident 649 had removed the resident's alarm twice today. CNA 7 stated Resident did have a sitter in the morning but not sure what is the sister schedule for this shift. During an observation on 05/05/21 at 9:19 AM, Resident 649 was trying to put on his clothes on the the resident was alone in the room. A concurrent interview was conducted; Resident 649 was confused to place, time. date and stated he wanted to go back home. A review of the facility's Policy Statement, titled Managing Falls and Fall Risk, dated 3/2018, indicated the facility staff will identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try to minimize the complications from falling. 44027 b. A review of Resident 174's Face Sheet, indicated the resident admitted to the facility on [DATE] with diagnoses that included left side hemiphlegia following cerebral infarction. A review of the MDS, dated [DATE], indicated Resident 174 had moderate impairment in memory and cognition (ability to think and reason) and required extensive assistance with one person on eating. During a concurrent observation and interview, on 5/5/21, at 1:18 PM, Resident 174 was in bed with a food tray in front of her. LVN 6 was providing supervision during the resident's meal and assisting the resident with eating. The dietary tag on the tray indicated no straw, and there was a straw in the milk carton. LVN 6 removed the straw when the surveyor asked LVN 6 if the resident was permitted to use a straw. LVN 6 stated the resident can not have a straw because she is on aspiration precautions (an action taken in advance to prevent something dangerous from happening). LVN 6 stated the resident had a stroke (the sudden death of brain cells due to a lack of oxygen, caused by blockage of blood flow or rupture of an artery to the brain) and might aspirate when using a straw. During a second observation and interview, on 5/5/21, at 3:53 PM, A Health shake was on Resident 174's tray at the resident's bedside. The straw was in the shake carton. LVN 8 stated to Resident 174 she needed to take the straw away because resident 174 might aspirate. A review of Resident 174's Physician Order dated 4/28/21, indicated No straw.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42781 Based on observation, interview and record review, the facility failed to ensure that a resident with an indwelling catheter (known as Foley catheter, a tube that allows urine to drain from the bladder into a bag that is usually attached to the thigh) tubing was not kinked for one of one sampled resident (Resident 183). This deficient practice had the potential to result in recurrence of urinary tract infection (UTI-an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney) that could to lead to urosepsis (a potentially life-threatening complication of urinary tract infection). Findings: A review of Resident 183's Facesheet (Admission Record) indicated the facility readmitted Resident 183 on 6/29/20. Resident 183's diagnoses included neuromuscular dysfunction of bladder (also known as neurogenic bladder, condition in which problems with the nervous system affect the bladder and urination, dysphagia (difficulty swallowing), and hyperlipidemia (an abnormally high concentration of fats or lipids in the blood). A review of Resident 183's Physician's order, dated 6/29/20 indicated for staff to start Foley catheter, french 18/10cc, attached to bedside drainage bag every shift for neurogenic bladder. A review of Resident 183's Minimum Data Set (MDS, a comprehensive assessment and care screening tool), dated 4/5/21 indicated the resident's cognitive skills (ability to think and process information) for daily decision making was intact. The MDS indicated Resident 183 required total dependence from staff for bed mobility, dressing, eating, toilet use and personal hygiene. During an observation on 5/3/21, at 9:49 AM, with Registered Nurse 6 (RN 6), Resident 183's foley catheter tubing was kinked. RN 6 released the foley catheter and to allow the urine to flow down the tubing into the urine bag. A concurrent interview was conducted; RN 6 stated it was important that the foley catheter should be free of kinks so that the urine output will be flowing freely to prevent back flow of the urine and not cause urine infection and to prevent urinary distension. During an interview on 5/6/21, at 11:23 AM, the Director of Nursing (DON) stated the foley catheter tubing should not be kinked. The DON stated when the foley catheter kinked the urine will go back up in the bladder it could cause spasms and discomfort to the resident. The DON stated foley catheter tubing should be draining and patent all the time. A review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, revised on September 2014, indicated for staff to check the resident frequently to be sure the is not lying on the catheter and to keep the catheter and tubing free of kinks.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 44290 Based on observation, interview and record review, the facility failed to ensure staff assessed and placed dressing on hemodialysis catheter (hallow tube inserted into a large vein for exchanging blood to and from a blood filtering machine and a patient) access site for one of three residents (Resident 103). This failure place Resident 103 at risk for developing an infection of the skin where the hemodialysis catheter is inserted or infection of the blood stream. Findings: During an observation on 5/4/21, at 8:00 AM in Resident 103's room, Residents 103's right chest hemodialysis catheter had no dressing over the insertion site. Insertion site is dry and crusted, no redness, swelling or drainage noted. During an interview on 5/4/21, at 12:20 PM LVN 1 stated, there should be Dressing on Resident 103's hemodialysis catheter. LVN 1 stated the resident had dialysis yesterday and dialysis nurses were supposed to put the dressing on the catheter insertion site. LVN 1 stated she will put one on now, so the resident would not get infection at the site. During a concurrent observation and interview on 5/4/21, at 1:28 PM, Resident 103's hemodialysis catheter has dressing over insertion site. LVN 1 stated, the dressing was not on the site when the resident came back from dialysis. LVN 1 stated she didn't notice this morning that the resident did not have the dressing on. LVI 1 state she did not check Resident 103's hemodialysis catheter site. During a review of the facility's policy and procedure (P&P) titled, Hemodialysis Access Care, dated 2010, the P&P indicated that the dressing change is done in the dialysis center post-treatment. The policy indicated if dressing becomes wet, dirty, or not intact, the dressing shall be changed by a licensed nurse trained in this procedure. A record review of Resident 103's Central Venous Catheter (CVC)/Permcath (a type catheter used for hemodialysis) After Instructions, undated, indicated there should be a dressing on the chest as long as the catheter is in place.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36925 Based on interview and record review, the facility failed to provide sufficient nursing staff to provide range of motion, application of splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion), and ambulation to 129 residents requiring a Restorative Nursing Assistant (RNA, nursing aide program that helps residents to maintain their function and joint mobility) program. This deficient practice had the potential to decrease the residents' range of motion and mobility, which could affect the residents' overall function. Cross reference F688 Findings: A review of the facility's policy entitled, Rehabilitative Nursing Care, revised in July 2013, indicated the facility's rehabilitation nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. The policy indicated the program included assisting residents to carry out prescribed therapy exercises. During an interview on 5/4/21, at 8:32 AM, the Director of Staff Development (DSD) stated there were two RNA staff in Station 2's subacute (area of the facility where individuals require more intensive services) area and two RNA staff in the skilled nursing area each day. A review of the May 2021 projected staff calendar for Station 2's subacute indicated one RNA was scheduled on 5/3/21, 5/4/21, 5/5/21, and 5/6/21. During an interview on 5/4/21, at 8:42 AM, Restorative Nursing Assistant 1 (RNA 1) stated she was the only RNA staff for Station 2's subacute on 5/3/21 and 5/4/21. RNA 1 stated the RNA's work schedule included 4-days on and 2-days off. RNA 1 stated two RNA staff worked two days per week. RNA 1 stated RNA staff's responsibilities included obtaining residents' weekly and monthly weights and performing range of motion exercises for 40 subacute residents. RNA 1 stated 24 of 40 residents were seen on 5/3/21 for range of motion during the 8-hour workday. RNA 1 stated Station 2's subacute required at least two RNA staff each day to prevent residents from developing contractures (deformity and joint stiffness). During an interview on 5/4/21, at 9:06 AM, the DSD stated it was important for residents to obtain RNA services to prevent contractures. The DSD described contractures as painful and can make care difficult for staff. A review of the facility's projected staff calendar for Station 1, 3, 4, 5 and 6 (skilled nursing area) for the month of May 2021 indicated one RNA was scheduled on 5/3/21, 5/4/21, 5/5/21, and 5/6/21. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/4/21, at 9:25 AM, RNA 2 stated RNA's responsibilities in the skilled nursing area included obtaining residents' weekly and monthly weights, performing range of motion exercises for 89 residents, and assisting residents with a feeding program. RNA 2 stated she was the only RNA scheduled on 5/3/21. RNA 2 stated that residents can have multiple physician's orders for range of motion to the arms and legs, splint application, and ambulation. RNA 2 stated being able to provide RNA services for 16-20 residents per day but unable to complete RNA sessions with all 89 residents alone. RNA 2 stated the facility used to provide one RNA for each nursing station, totaling at least 4-5 RNA staff per day in the skilled nursing area, from Monday to Friday. RNA 2 stated that it was important for residents to receive RNA services to prevent contractures and decline in function. During an interview on 5/5/21, at 2:41 PM, the DSD reviewed the skilled nursing staffing, which was posted in the facility for 5/3/21. The facility's posted staff indicated there were two RNA staff for 5/3/21. The DSD stated that there was only one RNA staff on 5/3/21. The DSD stated that RNA 5 was pulled from RNA to perform Certified Nursing Assistant (CNA) duties due to staffing shortage. During an interview on 5/6/21, at 11:59 AM, Minimum Data Set Assistant (MDS 2) stated MDS 2's other role was the RNA Supervisor. MDS 2 stated that the facility did not have enough staff since the RNA staff were being pulled to perform CNA work. A review of the facility's policy, titled, Staffing, revised April 2007, indicated the facility maintains adequate staffing on each shift to ensure that our resident's needs and the services are met.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 42781 Based on observation, interview and record review, the facility failed to ensure the nurse staffing information on the posting was accurate for 3 of 5 days (5/3/21, 5/4/21, 5/5/21). This deficient practice had the potential to result in misinformation to the residents and the public regarding the facility's nursing staffing data. Findings: During an observation with Registered Nurse 6 (RN 6), on 5/3/21 at 2:12 PM, a daily nurse staffing information was posted by the sub-acute nursing station, and next to the entrance of the front lobby. During a review of the actual staffing sign in sheet on 5/3/21, at 3:01 PM with Director of Staff Development (DSD 1), the nurse staffing information and the actual staffing sign in sheet for the staff who worked reflected the following: 1. On 5/3/21 for the 11 PM to 7 AM shift, there were 16 certified nurse assistants (CNAs) on the nursing staffing posting while the sign in sheet reflected 14 CNAs. 2. On 5/4/21 for the 7 AM to 3 PM shift, there were 19.2 CNAs on the nursing staffing posting while the sign in sheet reflected 15 CNAs. 3. On 5/5/21 for the 11 PM to 7 AM shift, there were 15.5 CNAs on the nursing staffing posting while the sign in sheet reflected 12 CNAs. During an interview, on 5/5/21 at 3:10 PM, DSD 1 stated the daily staff posting on 5/3/21, 5/4/21, 5/5/21 should be based on the number of staff working and hours every shift. DSD 1 stated it was important that the daily posting was correct for the visitors and family members to know who and how many people worked and provided care to the resident. During a review of the facility's policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, dated August 2006, the P&P, indicated within two hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPN's and LVNs) and the number of unlicensed nursing personnel (CNA's) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33670 Based observation, interview and record review, the facility failed to ensure 4 of 5 sampled residents (Residents 96, 95, 117 and 146) were free of unnecessary medications. a. For Resident 96, the resident was not provided non pharmacological (non-medication options) interventions for inability to sleep, and all hours of sleep were not measured during the day, evening and nights while receiving Trazodone (a medication used to relieve falling or remaining asleep) for inability to sleep. This deficient practice had resulted in Resident 96's hours of sleep were not counted properly which had the potential to result in adverse side effect (untoward effect or reaction) to the medication. b. For Resident 95, the resident's gradual dose reduction (GDR, slowly reducing the frequency and dose of drug) was not performed while receiving Seroquel (medication that affects mental, mood and behavior). This deficient practice placed Resident 95 at risk of receiving unnecessary medications that could result in adverse (harmful) side effects and complications to its use. c. For Resident 117, a GDR was not performed while the resident was receiving Zyprexa (medication that affects mental, mood and behavior). This deficient practice placed Resident 117 at risk of receiving unnecessary medication that could result in adverse side effects and complications to its use. d. For Resident 146, non-pharmacological approaches to address the behavior of pulling of medical tubing were not implemented prior administration of Ativan (medication to relieve anxiety [feeling fear of the unknown) to the resident. This deficient practice placed Residents 146 at risk for developing adverse side effect of psychotropic medication. Findings: a. A review of Resident 96's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic respiratory failure (inadequate exchange of oxygen in the respiratory system) and depression. A review of the Minimum Data Set (MDS, a resident assessment and care screening tool), dated 2/26/21, indicated Resident 96 does not speak, sometimes able to express needs and wants. The MDS indicated Resident 96 had severe cognitive (ability to think and reason) impairment and required total assistance with one person assistance on bed mobility and personal hygiene. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Resident 96's Physician's Order, dated 3/30/21, indicated to administer Trazadone 50 milligrams (mg) daily at bedtime for major depressive disorder manifested by inability to sleep. During an observation on 5/3/21 at 9:26 AM Resident 96 was observed awake with eyes open, unable to talk and does not follow commands. During an observation and interview on 5/6/21 at 12:31 PM, Licensed Vocational Nurse 6 (LVN 6) stated Resident 96 was non verbal and sometimes yells out but the resident does not follow commands. Resident 96 was observed calm, awake eyes open. During an observation on 5/04/21 09:12 AM , 5/04/21 at 11:29 AM, 5/05/21 at 8:53 AM, 5/6/21 at 8:16 AM. and 5/06/21 at 2:36 PM, Resident 96 was observed asleep. During a concurrent interview with (LVN 3) and review of Resident 96's Physician Order and the Medication Administration Record (MAR) on 5/6/21 at 8:16 AM, the MAR indicated Resident 96's hours of sleep was monitored during the evening and night shift and not during the day shift. LVN 3 stated there was no documented evidence a non pharmacological intervention was provided prior to administration of Trazadone. LVN 3 stated it was important to know the total hours of sleep during all shifts to evaluate if the resident need the Trazadone. A review of the MAR indicated Resident 96 had the following hours of sleep on the following dates: 5/1/21 evening shift-8 hours and night shift-2 hours total 10 hours 5/2/21 evening shift-1 hour and night shift 5 hours-total 6 hours 5/3/21 evening shift-1 hour and night shift-5 hours total 6 hours 5/4/21 evening shift-5 hours and night shift 5 hours-total 10 hours 5/5/21 evening shift-2 hour and night shift-6 hours total 8 hours 5/6/21 evening shift-not documented hours and night shift 6 hours-unknown hours A review of the Psychotropic Assessment, dated 3/30/21, indicated Resident 96 was confused. The assessment indicated non pharmacological interventions included to provide verbal cues, remove stimuli and reorientation. A review of the plan of care, titled Psychotropic Medications, dated 3/30/21, indicated Resident 96 required the use of Psychotropic Drugs for depression. To prevent ASE (Adverse Side Effect) to the medication, Resident 96 will evaluate behavior and medication as necessary and monitor behavior by hashmarks every shift. 28074 b. During an observation on 5/3 21, at 12 p.m., Resident 95 was sitting in bed and eating lunch. The resident ate 100% of her lunch meal. The resident was calm without agitation and striking-out behavior. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 95's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD- progressive disease, osteo arthritis (inflammation of one or more joints, which results in pain, swelling, stiffness, and limited movement) and heart disease. A review of the MDS dated [DATE], indicated Resident 95 had short and long-term memory problems. The resident was severely impaired in cognitive skills for daily decision-making, usually able to understand others and usually made herself understood. The MDS indicated the resident required limited assistance to extensive assistance from the staff for most activities of daily living. The MDS Sections D and E for Mood, and Behavioral Symptoms indicated the resident did not have any behavioral symptoms or concerns. A review of the Physician's Order dated 7/31/20, indicated to administer Seroquel 12.5 milligrams (mg) daily by mouth at bedtime for schizophrenia (a group of brain disorders in which people interpret reality abnormally) manifested by screaming and yelling. A review of the Monthly Psychotropic Summary Sheet dated from 1/1/21 to 4/30/21, indicated Resident 95 had aggressive behavior and episodes of refusing care are as follows: 1/1/21 to 1/31/21, there were 58 episodes 2/2/21 to 2/28/21, there 54 episodes 3/1/21 to 3/31/21, there 77 episodes 4/1/21/to 4/30/21, there 47 episodes. During an interview with LVN 7 on 5/3/21, at 4 p.m., she stated that Resident 95's behavioral monitoring was aggressive behavior and refusing care. LVN 7 stated that Resident 95 did not exhibit any episodes of screaming and yelling. LVN 7 was also asked if an attempt was made for a gradual dose reduction (GDR) for Seroquel, LVN 7 stated that she will call the physician for clarification of the specific behavior/ indication and for the gradual dose reduction of Seroquel. c. During an observation on 5/3/21, at 3:30 p.m., Resident 117 was observed ambulating along the hallways. The resident was quiet and calm. A review of the resident's 117's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included hypertensive heart disease (high blood pressure) and lack of coordination. A review of the MDS, dated [DATE], indicated the resident completed the brief interview for mental status without recall problems, had clear speech, was able to understand others and made herself understood. The MDS indicated the resident required supervision from the staff for most activities of daily living. A review of the Physician's Order dated 3/18/20, indicated to administer Zyprexa 5 milligrams (mg) by mouth every hour of sleep (qhs) for schizophrenic disorder manifested by (m/b) talking to herself and paranoid thinking being watched by others. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the LVN 7 on 5/4/21, at 10 a.m., she stated that no gradual dose for the reductions for the Zyprexa were attempted since the medications were ordered in 2020. On 5/4/21, 10:30 a.m., during an interview with CNA 7, she stated the resident did not present any danger to peers and staff. During an interview with LVN 6 on 5/4/21, at 11 a.m., she stated there was no documented evidence a gradual dosage reduction for the Zyprexa was attempted and no documentation that a gradual dosage reduction was clinically contraindicated. 44635 d. A review of Resident 146's Face Sheet, indicated the facility admitted the resident on 3/23/21 with diagnoses of chronic respiratory failure (a condition that results in the inability to effectively exchange carbon dioxide and oxygen) and dependence on ventilator (a machine that provides mechanical ventilation by moving breathable air into and out of the lungs). A review of Resident 146's History and Physical Examination, dated 3/24/21, indicated resident was admitted with tracheostomy tube (a tube inserted in the neck below the vocal cords for breathing) and percutaneous endoscopic gastrostomy tube (PEG, a flexible feeding tube placed into the stomach). A review of Resident 146's medical record titled Patient Care Plan: Psychotropic Medication, dated 3/23/21, indicated care plan did not include Ativan and did not include any non-pharmacological approach to address the behavior of tube pulling. A review of Resident 146's MDS, dated [DATE], indicated resident had severe impairment for daily decision making and required extensive assistance for activities in daily living (ADLs such as transferring, dressing, toilet use and personal hygiene). A review of Resident 146's Physician Orders, dated 4/30/21, indicated an order for the resident to receive Ativan 0.5 milligrams every six hours as needed for anxiety as manifested by pulling of medical equipment or tubing for a period of 14 days. During an observation on 5/3/21, at 10:45 p.m., Resident 146 was lying in bed with eyes closed and with calm and even breathing. During an interview on 5/6/21, at 2:47 p.m., Registered Nurse 1 (RN 1) was unable to provide any documentation that staff routinely used non-pharmacological intervention to prevent Resident 146 from pulling his tubes. During an interview on 5/6/21, at 4:14 p.m., Registered Nurse 6 (RN 6) stated that she understood the importance of psychotropic medication review because sometimes residents don't need it and medication is given to them to control their behavior.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44290 Based on Observation interview and record review, the facility failed to ensure the medication error rate was not 5 percent or greater. There were 2 errors observed during medication pass observation with 25 opportunities which yield 7.69% error rate. a. For Resident 103, the Vitamin C (a vitamin supplement) morning dose was omitted from the medication administered. This failure had the potential to cause a Vitamin C deficiency in resident 103 which could result in delayed wound healing, bruising, and painful and swollen joints. b. For Resident 101, the gastric tube (a tube surgically inserted into the stomach to deliver fluids and medications) was not flushed prior to medication administration. This deficient practice had the potential for the GT to clogged and adverse (undesired effect) drug reaction to the medications administered. Findings: a. A review of Resident 103's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cutaneous abscess of the lower limb (skin infection with pus on the lower leg). During a medication pass observation on 5/4/21 at 7:45 a.m., Licensed Vocational Nurse 1, (LVN 1) administered medication to Resident 103. LVN 1 did not administer Vitamin C to Resident 103. A review of Resident 103's electronic medication record (eMAR), indicated the Physician ordered to administer Vitamin C 500 mg liquid twice a day (BID) to Resident 103. During an interview on 5/4/21, at 9:05 a.m., LVN 1 stated, she did not see the order for Vitamin C 500 milligrams on the EMAR during the medication administration therefore the medication was not given. 42781 b. A review of Resident 101's Facesheet (Admission Record) indicated that the facility admitted Resident 101 on 7/12/19. Resident 101's diagnoses included hypertension (high blood pressure), and epilepsy (a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain). A review of Resident 101's Minimum Data Set (MDS, a comprehensive assessment and care screening tool), dated 3/8/21 indicated Resident 101 required total dependence from staff for bed mobility, dressing, eating, toilet use and personal hygiene. (continued on next page)

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	056431	A. Building B. Wing	05/07/2021

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication pass observation on 5/4/21, at 8:58 AM, License Vocational Nurse 1 (LVN 1) did not flush the tube feeding with 15 ml to 30 ml of water before administering Docusate Sodium (stool softener) 100 milligram (mg) 2 tablets. During an interview on 5/4/21, at 9:38 AM with LVN 1, LVN 1 stated she did not remember if she flushed the tube feeding with water before she administered the medication. LVN 1 also stated it was important to flush the tube feeding with water before administering medication to make sure the tube was patent and with no residuals. During an interview on 5/6/21, at 11:26 AM with Director of Nursing (DON), she stated tube feeding should be flushed with water prior to giving medications. DON also stated it was important to flush the tube feeding with water so that the feeding would not mix with the medication, to cleanse the tube and to made sure the tube was patent before administering medication. During a review of the facility's policy and procedure (P&P) titled, Administering Medications through an Enteral Tube, the P&P, indicated dated March 2015, the P&P indicated to flush tubing with 15 to 30 ml warm sterile water (or prescribed amount).

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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** 44290 Based on observation, interview and record review, the facility failed to ensure all drugs and biological used in the facility are labeled in accordance with professional standards and failed to remove expired medications from medication carts and storage rooms. a. Resident 192's medication was found outside of its protective packet and with out an open and expiration dates. b. Resident 71's medication was found stored past the use by date. These failure had the potential for Resident 192 and Resident 71 receiving medications that past the use by date and were not stored properly and placed the residents at risk for receiving ineffective medications. c. Station 6's medication cart and Medication Storage room [ROOM NUMBER] had expired medications. These deficient practices had the potential for residents to receive expired medication which can affect the residents' well-being. Findings: a During a concurrent inspection of the medication cart (Med cart 1-1) and interview with Licensed Vocational Nurse 1 (LVN 1) on 5/5/21, at 2:08 pm, one Ipratropium Bromide 0.5 mg /Albuterol Sulfate 3 mg foil packet (a medication used to open up air passages in the lungs, and help control symptoms of lung diseases , such as asthma) for resident 192 was found opened with four of five vials/unit doses left. These vials had fallen out of their protective foil packet without the open date or expiration date was written on package. LVN 1 stated the medication packet for Resident 192 should have been dated with date the foil packet was opened and use by date. A review of the Ipratropium Bromide 0.5 mg /Albuterol Sulfate 3 mg foil packet instructions, under the storage condition section, indicated that the unit dose should remain stored in protective foil pouch. Once removed from foil pouch, the individual vials should be used with in one week. b. During the same inspection of Med Cart 1-1 with LVN 1, Resident 71's Humilin R insulin (medication to treat high blood sugar levels in patients with diabetes) was found opened, with an open date of 3/19/21. LVN 1 stated the insulin for Resident 71 was good for 28 days after opening and should have been discarded so the resident would not receive old or bad medicine. A review of the Humilin R instructions, dated November 2019, under How Should I store Humilin R, indicated opened vials should be thrown away at 31 days, even if there is still insulin left in the vial. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44037 c. During an observation on 5/05/21 at 3:30 PM, the following medications were found in the medication cart of Station 6: 1. Metoclopramide 10 mg tab (used to treat the symptoms of slow stomach emptying in patients with diabetes) expired on 4/22/21. The packet was not marked Expired and was stored together with the other medications. 2. Ondansentron HCL 4 mg tab (used to prevent nausea and vomiting) expired on 2/22/21 and was in the drawer. The medication was marked, Expired. 3. Ferrous Sulfate 220 mg/5 ml (Gerjcare Iron Supplement Liquid, used to treat iron deficiency), a medication intended for multiple use was open and not dated. During a subsequent interview with Licensed Vocational Nurse 17 (LVN 17), she stated that expired medications should be removed from the medication cart immediately and medications that have been opened should be dated accordingly. During an interview on 5/06/21 at 8:22 AM, the Director of Nursing (DON) stated that licensed nurses should check all medications in the medication cart every shift and should remove all medications that are expired. During an observation at the Medication Storage room [ROOM NUMBER] on 05/06/21 at 08:45 AM, four Major-Prep Hemorhoidal Ointments (used to temporarily relieve swelling, burning, pain, and itching caused by hemorrhoids) and four Geri-Care Nephro Vitamins that expired on 11/2020 and 7/2020 respectively were kept in the storage room for use. During an interview on 5/06/21 at 10:01 AM, the Central Supply Supervisor stated that he stocks up the medication storage room with non-prescribed medications. He stated that medications that are expired should be removed immediately and properly discarded. A review of the facility's policy, titled Storage of Medications, revised in April 2007, indicated that the nursing staff shall be responsible for maintaining medication storage and the facility should not use discontinued, outdated, or deteriorated biological.

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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. 28074 Based on observation, interview, and record review, the facility failed to ensure that food items were stored under sanitary conditions as indicated in the policy and procedure by failing to: 1. Ensure not to store a dented food can in the pantry. 2. Ensure to maintain the floors behind standing refrigerators clean. These deficient practices had the potential for residents to be at risk for contracting food-borne illnesses. Findings: During an initial tour of the kitchen and an interview on 5/3/2021 at 8:35 am, the Director of Nutrition/Environment stated there was one 110 ounce (a unit of weight) tomato dented can stored with other non-dented cans on the rack, and there was an accumulation of dust particles on floors behind standing refrigerators. The Director of Nutrition/Environment stated the dented cans should be separated from the non-dented cans. A review of the facility's Food Service Management policy and procedure dated 2018, indicated damaged cans and packages to be returned to Vendor and to have an inspection system of cans and packages that were delivered to ensure safety of foods to residents, monthly check of cans and packages in storerooms. A review of the facility's Cleaning Procedures policy dated with the year of 2018, indicated floors were cleaned and maintained to avoid accumulation of dirt, food particles, dust, grime, grease, water spots and vermin.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28074 Based on interview and record review, the facility failed to ensure an inventory list of personal belongings was completed for one of 35 sampled Residents (Resident 75). The facility also failed to follow the facility's policy on narcotic (controlled substance) medication administration for one of one sampled resident (Resident 710). These deficient practices placed Resident 75's personal property at risk for theft and loss and had the potential to result in Resident 710's controlled medication diversion (a medical and legal concept involving the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit use). Findings: a. A review of the Admission Record indicated Resident 75 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 75's diagnoses included fracture (broken bone) of the right femur (thighbone), chronic obstructive pulmonary disease (COPD, progressive disease that gets worse over time and makes it hard to breath), dementia (gradual loss of brain function and a decline in mental functioning) and psychosis (severe mental disorder in which you lose touch with reality). The Minimum Data Set (MDS, a standardized assessment tool), dated 2/18/21, indicated the Resident 75 had short and long-term memory problems, was able to make herself understood, but had the ability to understand others. Resident 75 required total assistance with activities of daily living. A review of Resident 75's Resident Inventory of Personal Effects (list of personal property), dated 5/23/19 and 11/16/19, indicated a blank form. There was no documented evidence that Resident 75's belongings were inventoried upon her admission and readmission to the facility. During a telephone interview with Resident 75's RP on 5/7/21, at 8:30 a.m., the RP stated, there were two boxes of clothing sent to the facility. The RP also stated Resident 75 used to have jewelries on her, but do not have it anymore. During a concurrent observation and interview with Licensed Vocational Nurse 8 (LVN 8) on 5/7/21, at 10 am, she confirmed Resident 75's Resident Inventory of Personal Effects forms, dated 5/23/19 and 11/16/19 were blank. LVN 8 added, personal items should have been listed upon Resident 75's admission and when new items were brought to the facility. LVN 8 also stated, it is the responsibility of everyone in the facility to log in the new items. A review of the facility's policy and procedures titled, Personal Property, revised on 9/2012, indicated te resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. 44635 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A review of Resident 710's Face Sheet (Admission Record), indicated the facility admitted the resident on 5/3/21 with diagnoses of osteomyelitis (bone infection), pressure ulcers (areas of damaged skin caused by staying in one position for too long), and anxiety disorder (a mental health disorder that involves extreme fear or worry). A review of Resident 710's Physician Orders for the month of May 2021, indicated for the resident to receive Diazepam (medication the treat anxiety), 5 milligrams, every eight hours as needed for anxiety. A review of Resident 710's Record of Controlled Substances (RCS), indicated Resident 710 received Diazepam on 5/5/21 at 9:30 p.m. A review of Resident 710's Medication Administration Record (MAR), dated May 2021, indicated Resident 710 did not receive Valium on 5/5/21 at 9:30 p.m. During an interview on 5/6/21, at 1:48 p.m., the Director of Nursing (DON) stated Resident 710 was assigned to Licensed Vocational Nurse 10 (LVN 10) for the evening shift on 5/5/21. The DON stated that a narcotic medication needs to be recorded in MAR after it was given. She further stated that narcotics taken out of medication cart without being recorded could create a diversion. The DON stated she would investigate this issue with her staff. During an interview on 5/6/21, at 2 p.m., with Resident 710, he stated that he received Diazepam last night at 9:30 p.m. During an interview on 5/6/21, at 3:45 p.m., with LVN 10, he stated that he applied the seven rights of medication administration when giving medications to residents (right patient, right drug, right dose, right time, right route, right reason and right documentation). A review of the facility's policy titled Administering Medications, dated December 2012, indicated that the individual administering the medication will record in the resident's medical record: the date and time the medication was administered; the dosage; the route of administration; the injection site (if applicable); any complaints or symptoms for which the drug was administered; any results achieved and when those results were observed; and the signature and title of the person administering the drug.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28074 Based on interview and record review, the facility failed to ensure the current physician certification for hospice (providing care for the sick or terminally ill) benefit was renewed for one of 4 sampled residents (Resident 75). This deficient practice had the potential for miscommunication regarding Resident 75's hospice care. Findings: A review of Resident 75's Admission Record indicated the facility admitted the resident on [DATE], with diagnoses of fracture (broken bone) of the right femur (thighbone), chronic obstructive pulmonary disease (COPD- progressive disease that gets worse over time and makes it hard to breath), dementia (gradual loss of brain function and a decline in mental functioning) and psychosis (severe mental disorder in which you lose touch with reality). A review of Resident 75's physician's order dated [DATE], indicated to admit Resident 75 under hospice care (providing supportive care to people in the final phase of a terminal illness and focus on comfort and quality of care, rather than cure). A review of Resident 75's Physician's Certification for Hospice Benefit had expired on [DATE]. During an interview on [DATE] at 11:26 am, Licensed Vocational Nurse 6 (LVN 6) stated Resident 75's should have an updated certification in the resident's clinical records. A review of the facility's Hospice Program policy and procedure with a revised date of [DATE], indicated the facility was responsible in obtaining the physician's certification and recertification of the terminal illness specific to each resident.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 33670 Based on observation, interview, and record review, the facility failed to develop, implement, and evaluate the appropriate plan of action to correct identified quality deficiencies by failing to: 1. Ensure residents at risk of developing or with contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints that could cause pain) were provided range of motion (ROM) exercises by the RNA (Restorative Nursing Assistant). The 11 of 11 sampled residents with contractures or at risk for developing contractures were not provided ROM exercises and/or placed assistive device to prevent contractures. There were 36 residents out of 107 residents developed contractures at the facility. This deficient practice had resulted in severe contractures and potential to result in additional contractures or worsened contractures of the residents with and at risk in developing contractures. 2. Ensure residents with pressure injuries (a skin tissue injury that result due to prolonged unrelieved pressure) were repositioned at least every two hours and provided pressure relieving devices. There were 7 of 10 sampled residents that were not repositioned or provided pressure relieving device and proper bed settings according to the weight. There were a total of 35 residents in the facility with pressure injuries excluding Stage 1 (non blanchable intact skin redness) pressure injury at the facility. This deficient practice had the potential to result in recurrence of healed pressure injury, development of new pressure injury and worsened pressure injuries. 3. Ensure the facility's internet and phone lines connections were in good functioning condition for the facility to receive phone calls and use the internet services. Family members and the responsible parties of Residents 91, 75, and 187 who were interviewed, stated it was difficult to get an update or communicate with the residents because the facility did not answer the phone or phone connections got disconnected. This deficient practice had resulted in the residents not to practice their rights to be informed about their health care conditions and/or allow the responsible parties to assist with the healthcare decisions when the residents does not have the capacity to decide for themselves. Cross reference to F552, F686 and F688 Findings: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. According to the survey findings there were 11 sampled residents that were not provided the range of motion exercises or provided a device to prevent contractures. A review of the Residents and Conditions of Residents, a Centers of Medicare and Medicaid Form 672 (CMS 672, a report of the current conditions of the residents at the time of the recertification survey), submitted by the facility on 5/3/2021, indicated 36 residents developed contractures at the facility out of 107 residents with contractures. During an interview with the Administrator (ADM) and the Director of Nursing (DON) regarding the Quality Assurance Program Improvement (QAPI) of the facility on 5/7/2021 at 1:03 p.m., the DON stated the facility started to implement action to prevent contractures. The DON stated there was no written plan of action at this time to indicate specific actions to be implemented and who would be responsible to ensure the actions were implemented. The DON also stated there had been shortage of staff beginning in the year due to the Corona virus -19 (COVID-19 a severe infection primary affects the respiratory system) pandemic (a worldwide infection) that resulted in the shortage of staff which the facility had identified as the problem. 2. According to the current survey findings there were 7 of 10 sampled residents who were not repositioned or provided pressure relieving device and proper bed settings according to the weight. During an interview on 5/7/2021 at 1:03 pm, the DON stated a plan of action was developed to address the concerns about the resident's pressure injuries but there was no one specific staff assigned to monitor and oversee and evaluate if the plan of action was implemented to determine if the actions were implemented accordingly. The written plan of action and evaluation of the action was requested from the facility on 5/7/2021 at 1:03 p. m., and was not provided. 3. During the survey, three family/responsible parties interviews of Residents 187, 91, and 75 stated the phone service was poor and no one answered the phone calls or phone connections gets disconnected. During an interview on 5/7/2021 at 1:47 pm, DON stated the phone line and internet issues were discussed during the quarterly meeting in January but there is still a problem with the phone calls not answered or dropped. During an interview on 5/7/2021 at 12:30 pm, the ADM stated she was aware of the issues about the internet problem in the facility which caused the incoming calls to drop or get disconnected when the internet connection was lost, which could be the reason why the phone calls of the responsible parties were lost or not answered. A review of the policy and procedure, titled Quality Performance and Quality Improvement Program-Governance and Leadership, dated 3/2020, indicated the responsibilities of the QAPI Committee were to: a. Collect and analyze performance indicator data and other information. b. Identify, evaluate, monitor and improve facility systems and processes that support the delivery of care and services. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c.Identify and help to resolve negative outcomes and/or care quality problems identified during the QAPI process. d.Utilize root cause analysis to help identify where identified problems point to underlying systematic problems. e.Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care. f.Establish benchmarks and goals by which to measure performance improvement.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28074 Based on observation, interview, and record review, the facility failed to provide a safe, sanitary environment to help prevent the spread of infections during the Coronavirus-19 (COVID-19, a respiratory illness that can spread from person to person) as indicated in the facility's policy and procedure by failing to: 1. Ensure Resident 75's call light (device used by a patient to signal his or her need for assistance from professional staff), was disinfected after the call light was found on the floor. 2. Ensure contaminated dust mops were covered. 3.Ensure to have personal protective equipment (PPE refers to protective clothing, helmets, gloves, face shields, goggles, facemasks and/or respirators or other equipment designed to protect the wearer from injury or the spread of infection or illness) readily available for staff and visitors to use for Resident 19 in the yellow zone (unit for residents who have been in close contact with known cases of COVID-19) . 4. Ensure licensed nurses label the enteral feeding (given through a tube into the stomach) tubing for Resident 76. 5. Ensure licensed nurses change Resident 35's intravenous (IV, via vein) administration set. 6. Ensure licensed nurses used a clean or aseptic technique (method used to prevent contamination with germs), when handling syringes during medication administration for Resident 101 and Resident 177. 7. Ensure staff doffed (removed) contaminated PPE when exciting a yellow zone room. 8. Ensure Resident 103's hemodialysis access (hallow tube inserted into a large vein for exchanging blood to and from a blood filtering machine and a patient) site was covered with a dressing (bandage, patch, a piece of soft material that covers and protects an injured part of the body). These deficient practices had the potential to spread infections between residents, staff, and visitors. Findings: 1. During an observation and interview on 5/07/2021, at 8:45 am, Certified Nursing Assistant 8 (CNA 8) picked Resident 75's call light that was lying on the floor behind the resident's head of the bed and placed it back to the resident without cleaning or disinfecting the call light. CNA 8 stated the call light should be cleaned before placing it back on the resident's bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Cleaning and Disinfection of Resident-Care Items and Equipment policy and procedure, with a revised date of July 2014, indicated the resident care equipment, including reusable items and durable medical equipment would be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) Blood borne Pathogens Standard. 36943 2. During an observation on 5/3/2021, at 9:36 am, there were soiled blue dust mops in an uncovered yellow container upon entry to the soiled laundry room. During an interview on 5/3/2021, at 1:25 pm, Infection Prevention Nurse 1 (IPN 1, nurse who helps prevent and identify the spread of infectious agents like bacteria and viruses in a healthcare environment), stated that any soiled laundry, including the blue dust mops, should be in closed containers. IPN 1 stated that it was important for soiled laundry to be secured in a closed container or closed bags to prevent cross-contamination. A review of the facility's policy, titled Laundry and Bedding, Soiled, with a revised July 2009, indicated to place contaminated laundry in a bag or container at the location where it was used. 42781 3. A review of Resident 19's Facesheet (Admission Record) indicated the facility readmitted Resident 19 on 4/31/2021 with diagnosis of gastro esophageal reflux disease (GERD - chronic condition in which stomach contents rise up into the tube connecting the mouth and stomach). A review of Resident 19's History and Physical dated 4/11/2021, indicated Resident 19 did not have the capacity to understand and make decisions. A review of Resident 19's Minimum Data Set (MDS, a comprehensive assessment and care screening tool), dated 1/25/2021 indicated Resident 19 required total dependence from staff for bed mobility, dressing, toilet use and personal hygiene. A review of Resident 19's Isolation Precaution care plan dated 5/1/2021, indicated the resident was on contact isolation (used to prevent the spread of diseases that can be spread through contact), and the interventions were to maintain isolation as indicated, and provide instructions to family and visitors and staff on proper infection control measures. During an observation and interview on 5/3/2021, at 2:04 pm, Registered Nurse 6 (RN 6) stated Resident 19 was in the yellow zone and there were no gowns readily available outside the room and stated PPE should be maintained outside Resident 19's room for anyone who should enter the room can don (put on) proper PPE. RN 6 also stated it was important for the staff to wear proper PPE to prevent spread of infection. During an interview on 5/6/21, at 11:25 am, the Director of Nursing (DON), stated PPE supplies should be replenished and should be available and maintained in the isolation cart outside Resident 19's room. (continued on next page)

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	056431	A. Building B. Wing	05/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Isolation - Initiating Transmission-Based Precautions, with a revised date of August 2019, indicated to ensure PPE was maintained outside the resident's room for anyone entering the room could apply the appropriate equipment. 4. A review of Resident 76's Face Sheet indicated the facility readmitted Resident 76 on 8/26/2020 with diagnoses of dysphagia (difficulty swallowing), neuromuscular dysfunction of bladder (condition in which problems with the nervous system affect the bladder and urination), and GERD. A review of Resident 76's MDS dated [DATE] indicated the resident was severely impaired in cognitive skills for daily decision making The MDS indicated Resident 76 required total dependence from staff for bed mobility, dressing, eating, toilet use and personal hygiene. A review of Resident 76's Physician's Order dated 4/3/2021, indicated for the resident to receive diabetic source AC (formula) at 70 cubic centimeter (cc, measurement of volume) per hour. During an observation and interview on 5/3/2021, at 10:49 am, RN 6 stated Resident 76's enteral feeding tube's label was undated. RN 6 stated the enteral feeding (given through a tube into the stomach) tubing should be changed every 24 hours and must have a date for the staff to know when would be the next time to change to prevent infection. During an interview on 5/5/2021, at 2:15 pm, the DON stated if Resident 76's enteral feeding tube was undated and not documented, it meant it was not done. DON stated the facility's Policy and Procedure for Infection Control Standards indicated for tubing used for enteral tube feeding to be changed every 24 hours. A review of the facility's undated policy and procedure titled, Infection Control Standards, indicated for the tubing used for enteral nutrition administration would be changed every 24 hours. 5. A review of Resident 35's Face Sheet indicated the facility readmitted Resident 35 on 8/22/2019 with diagnoses of diabetes (a condition that affects the way the body processes blood sugar), and hyperlipidemia (an abnormally high concentration of fats or lipids in the blood). A review of Resident 35's MDS dated [DATE], indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS indicated Resident 35 required total dependence from staff for bed mobility, dressing, eating, toilet use and personal hygiene. A review of Resident 35's Physician's Order dated 4/26/2021, indicated to change the resident's intravenous (IV, via vein) administration set (tubing) every three days and to administer Invanz 1 gram (medication to treat infection) every 24 hours for seven days for urinary tract infection (UTI - an infection in any part of your urinary system) until 5/2/2021. A review of Resident 35's untitled care plan dated 5/4/2021, indicated a peripheral catheter (IV line) was inserted on the resident's left hand on 4/26/2021. During an observation and interview on 5/3/2021 at 10:31 am, RN 6 stated Resident 19's peripheral intravenous label was dated 4/26/2021. RN 6 stated the resident's IV site should be changed every 72 hours and it was seven days Resident 19 had the peripheral IV on the resident's left hand. RN 6 stated it was important to change the peripheral IV site to avoid infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and a record review of Resident 35's medical record on 5/6/21 at 11:17 am, DON stated the resident's peripheral IV site should be changed within 48 to 72 hours after insertion. A review of the facility's undated policy and procedure titled, Infection Control Standards, indicated peripheral catheters would be changed every 48 to 72 hours or per manufacturer's guidelines and immediately upon suspected contamination or complication. 6a. During a review of Resident 101's Face Sheet indicated the facility admitted Resident 101on 7/12/2019 with diagnoses of hypertension (high blood pressure), and epilepsy (a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain). A review of Resident 101's History and Physical dated 8/23/2020, indicated Resident 101 did not have the capacity to understand and make decisions. A review of Resident 101's Physician's Order dated 12/9/2020 indicated for the resident to receive diabetic source AC. During a review of Resident 101's MDS dated [DATE] indicated Resident 101 required total dependence from staff for bed mobility, dressing, eating, toilet use and personal hygiene. During an observation and interview on 5/4/2021 at 8:58 am, Licensed Vocational Nurse 12 (LVN 12) stated she did not rinse the used syringe after giving medication to Resident 101 via enteral tube. During an interview on 5/4/21 at 9:41 LVN 12 stated she was supposed to rinse Resident 12's syringe after she used it. LVN 12 stated it was important to rinse the syringe after use because it might be dirty and could cause infection. 6b. A review of Resident 177's Face Sheet indicated the facility readmitted Resident 177 on 3/22/2021 with diagnoses of hypertension and dysphagia (difficulty swallowing). A review of Resident 177's Physician's Order dated 3/22/2021 it indicated for the resident to receive diabetic source AC. A review of Resident 177's MDS dated [DATE] indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS indicated Resident 177 required total dependence from staff for bed mobility, dressing, eating, toilet use and personal hygiene. During an observation on 5/5/2021at 9:05 am, inside Resident 177's room, LVN 13 stated she did not rinse Resident 177's syringe after she administered the medication via enteral tube. During an interview on 5/5/2021 at 9:08 am LVN 13 stated her practice was to rinse Resident 177's at the end of her shift and not after every use. During an interview on 5/6/2021 at 11:26 am DON stated the syringes used in giving medications should be cleaned or rinsed after every use to prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated policy and procedure titled, Infection Control Standards, indicated strict aseptic technique would be used when changing tubing connections. 44027 7. During an observation on 5/5/2021 at 9:20 am, the Maintenance supervisor did not remove his isolation gown when he exited room A (Room A is designated a yellow zone room). During an interview on 5/5/2021 at 9:28 am, Maintenance supervisor stated he was supposed to remove the isolation gown before he left room A to prevent the potential spread of COVI-19. A review of the facility's mitigation plan with a revised dated of 4/12/2021 indicated, staff would doff PPE (personal protective equipment) when exiting a yellow zone area. 44290 e. A review of Resident 103 Face Sheet indicated the facility admitted the resident on 12/15/2017 and readmitted the resident on 2/10/2021 with diagnosis of dependence on renal dialysis. A review of Resident 103's Renal Dialysis care plan dated 4/21/2021 indicated the resident's dialysis access catheter was on the resident's right upper chest and for the staff to inspect the dressing for signs and symptoms of infection. During an interview on 5/4/2021 at 12:20 pm LVN 1 stated Resident 103 did not have a dressing over the insertion site. LVN 1 stated there should be Dressing on to prevent infection. A review of the facility's policy and procedure titled, Hemodialysis Access Care, dated 2010, indicated that the access site was to be kept clean at all times.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44037 Based on interview and record review the facility failed to provide a functional phone connection for the residents and visitors. This deficient practice resulted for the residents' family members not to be able to communicate with the residents and with facility staff. a. During an interview on 5/7/21, at 8:53 a.m., RP 1 stated the biggest complaint about the facility was the terrible phone service. RP 1 attempted to call multiple times this past week, but the receptionist did not pick up. A review of the map indicated the facility had six nursing stations. A review of the facility's census, dated 5/3/21, indicated the facility had 212 residents. During an interview on 5/7/21, at 1:03 p.m., Administrator (ADM) stated the facility had only three telephone lines. Director of Nursing (DON) was aware the phone lines were problem since physicians had difficulty calling the facility. The facility contacted the phone company and installed another router. ADM and DON were aware the additional router did not resolve the telephone service problem. b. During an interview on 5/3/21 01:47 PM with LVN 4, who states communication with Resident 91 are made with daughters or thru Google translator. During a telephone interview on 5/4/21 at 11:50 AM with Resident 91's family member (FMML 2B), she stated was unable to speak with staff regarding resident's health status on multiple occasions last year because phone calls were not being answered or calls were being transferred to nurse stations other than Resident 91's. c. During a telephone interview on 5/3/21 at 12:16 PM, Resident 187's family (FAM 1) stated she and other family members were not updated or informed of the Resident 187 change of condition for months. FAM 1 stated, for the past six months when she calls the facility to inquire about Resident 187's status, the phone rings repeatedly and no one would answer the phone, or if the call transferred to another area, the call dropped and the facility did not call FAM 1 back. During an interview on 5/7/21 at 12:30 PM, the Administrator (ADM) stated, she was aware of the issues about the internet problem in the facility which caused the incoming call to drop or get disconnected. The ADM stated the lost internet connection could be the reason for the phone calls not to be answered. During an interview on 05/07/21 at 1:03 PM, the DON stated the concern was brought to the Quality Assurance Program Improvement Commitee meeting in the last quarter but the phone lines and internet connections are still a problem.