STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Riverside Postacute Care	8781 Lakeview Avenue Riverside, CA 92509

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39503 Based on observation, interview, and record review, the facility failed to provide accommodation of needs for two of 40 residents reviewed (Residents 4 and 147), when: 1. Resident 4's call light string was not within the resident's reach. In addition, the resident did not have the appropriate call light device that he would be able to use if he needed to call for assistance; and 2. Resident 147's call light button was not within the resident's reach. These failures resulted for residents not to have a means of directly contacting the staff for assistance. Findings: 1. On February 3, 2019, at 12:18 p.m., a concurrent observation was conducted with Licensed Vocational Nurse (LVN) 1. Resident 4 was observed lying down in bed, turned on his left side and the call light string was clipped on the right side of the bed. Resident 4's both arms were contracted, the right arm was straightened out and the left arm was bent. Resident 4 shook his head when asked if he could reach the call light string and if he could pull the call light string to call for assistance. LVN 1 tried to clip the call light string on Resident 4's left side but the string was too short. In a concurrent interview, LVN 1 verified Resident 4's both arms were contracted and the resident needed assistance in turning from side to side. LVN 1 stated the call light should have been within the resident's reached at all times. LVN 1 stated Resident 4 should have been given the touch pad call light where the resident could press on it with the side of his head or cheek if he needed to call for assistance. On February 5, 2019, Resident 4's record was reviewed. Resident 4 was admitted to the facility on [DATE], with diagnoses that included muscle weakness. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 4's Minimum Data Set (MDS - an assessment tool) dated November 29, 2018, indicated Resident 4 was a total dependence on bed mobility and had an impairment on upper extremities. The facility's policy and procedure titled, Quality of Life - Accomodation of Needs, dated January 2018, was reviewed. The policy indicated, .Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being . The resident's individual needs and preferences shall be accomodated to the extent possible . 32191 2. On February 5, 2019, at 3:30 p.m., Resident 147 was observed lying down in bed, stated she felt cold. Resident 147 further stated she wanted to call the nurse to ask for a cup of hot chocolate but she was unable to reach the call light [NAME]. Resident 147 stated she came back from the dialysis treatment and the nurse who assisted her back to bed did not put her call light within reach. Resident 147's call light button was observed hanging on the side of the wall behind the bed. Resident was unable to reach for a call light button. A concurrent observation and interview were conducted with the Director of Nursing (DON) 1, and Certified Nursing Assistant (CNA) 1. DON 1 and CNA 1 acknowledged and confirmed Resident 147 call light button was hanging on the side of the wall behind the bed and was not in resident's reach. DON 1 further stated the call light should have been within the resident's reach at all times. On February 5, 2019, Resident 147's record was reviewed. Resident 147 was admitted to the facility on on January 3, 2019, with diagnoses that included weakness. The history and physical dated January 7, 2019, indicated, Has the capacity to understand and make decisions . The facility's policy and procedure titled, Answering The Call Light, dated January 2017, was reviewed. The policy indicated, .The purpose of the procedure is to respond to the resident's request and needs .

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32191 Based on observation, interview, and record review, the facility failed to promote and facilitate self-determination for one of 40 residents reviewed (Resident 147), when the resident's requested for incontinence care prior to eating her lunch meal on February 3, 2019, was not provided. This failure resulted for the resident not [NAME] able to exercise her right including her preferences. Findings: On February 3, 2019, at 1:20 p.m., during lunch meal observation, Resident 147 was observed lying in bed. Resident 147 stated she did not eat her lunch. On February 2019 at 1:45 p.m., an interiew was conducted with the Assistan Director of Nursing (ADON). The ADON stated Resident 147 refused her lunch. On February 3, 2019, a concurrent interview was conducted with Resident 147. Resident stated, she did not refused her lunch meal she wanted to be clean first because she feel hot in her buttom. Resident 147 stated the Certified Nursing Assistant (CNA) took her lunch tray out, and stated she cannot clean her because the lunch tray was on the overbed table. On February 3, 2019, at 1:55 p.m., the Director of Nursing (DON) 2 confirmed and acknowledged Resident 147 was not able to eat her lunch because she needed to be clean first. On February 5, 2019, at 4:56 p.m., an interivew was conducted with DON 1. DON 1 stated CNA should have provided Resident 147 incontinence care right away as requested. On February 5, 2019, Resident 147's record was reviewed. Resident 147 was admitted to the facility on [DATE]. The History and Physical dated January 7, 2019, indicated, Has the capacity to understand and make decisions . The facility's policy and procedure titled, Resident Rights , dated January 2018, was reviewed. The policy indicated, .Employees shall treat all residents with kindness, respect, and dignity .excercise his or her rights as a resident .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36684 Based on interview and record review, the facility failed, for seven of 26 residents (Residents 46, 40, 138, 108, 38, 276, and 155), to ensure an Advance Directive (AD- written instruction such as living will or durable power of attorney for health care about the provision of care and services the resident preferred when he is no longer able to decide for himself) was initated and/or discussed with the resident, family member, and/or legal representatative upon admission to the facility. In addition, for Resident 38, the facility failed to ensure the resident was provided the right to receive or refuse medical care and/or treatment when the facility had the resident, who did not have the capacity to make decisions, sign her own consent to treat and advance directives. These failures had the potential for the residents to receive unnecessary care/treatment and services. Findings: 1. On February 7, 2019, at 10:34 a.m., Resident 46's record was reviewed with the Social Service Director (SSD). Resident 46 was admitted to the facility on [DATE]. Resident 46's latest History and Physical examination form, completed by the physician dated October 30, 2018, indicated Resident 46 had the capacity to understand and make decisions. The completed Physician's order for Life-Sustaining Treatment (POLST- form completed by the resident and/or legal representive, that records the resident's treatment preferences in the event of a medical emergency) dated November 13, 2018, signed by the resident indicated Resident 46 did not have an AD. In a concurrent interview, the SSD stated she was unable to find documented evidence an AD was initiated and/or discussed with the resident upon her admission to the facility. The SSD stated the SSD or Admissions Coordinator should have discussed the AD with the resident since she was self-responsible (had the capacity to understand and make medical decisions for herself) upon her admission to the facility, and updated quarterly during the care conference meetings. 2. On February 4, 2019, Resident 40's record was reviewed. Resident 40 was admitted to the facility on [DATE], with diagnoses that included schizophrenia (a type of mental disorder). The completed Physician's order for Life-Sustaining Treatment (POLST- form completed by the resident and/or legal representive, that records the resident's treatment preferences in the event of a medical emergency), dated February 7, 2017, was signed by Resident 40's Responsible Party (RP- person legally authorized to make medical decisions for the resident) indicated Resident 40 did not have an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a concurrent interview, the SSD stated she was unable to find documented evidence an AD was initiated and/or discussed with the resident and/or the RP upon his admission to the facility. The SSD stated the SSD or Admissions Coordinator should have discussed the AD with the resident and/or RP upon her admission to the facility, and updated quarterly during the care conference meetings. 3. On February 11, 2019, at 2:03 p.m., Resident 138's record was reviewed with the Social Service Director (SSD). Resident 138 was admitted to the facility on [DATE], and with a re-admitted [DATE]. The History and Physical Examination form, completed by the physcian dated January 22, 2019, inidcated Resident 138 had the capacity to understand and make decisions. The completed Physician's order for Life-Sustaining Treatment (POLST- form completed by the resident and/or legal representive, that records the resident's treatment preferences in the event of a medical emergency), dated October 10, 2017, was signed by Resident 138 indicated the resident did not have an AD. In a concurrent interview, the SSD stated she was unable to find documented evidence an AD was initiated and/or discussed with Resident 138 upon her admission to the facility. The SSD stated the SSD or Admissions Coordinator should have discussed the AD with the Resident 138 upon her admission to the facility, and updated quarterly during the care conference meetings. 4. On February 11, 2019, at 9:48 a.m., Resident 108's record was reviewed with the Social Service Director (SSD). Resident 108 was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive disease that destroys memory and other important mental functions). The completed Physician's order for Life-Sustaining Treatment (POLST- form completed by the resident and/or legal representive, that records the resident's treatment preferences in the event of a medical emergency) dated April 29, 2015, was signed by Resident 108's Responsible Party (RP- person legally authorized to make medical decisions for the resident) indicated Resident 108 did not have an AD. In a concurrent interview, the SSD stated she was unable to find documented evidence an AD was initiated and/or discussed with Resident 108's RP upon his admission to the facility. The SSD stated the SSD or Admissions Coordinator should have discussed the AD with Resident 108's RP upon his admission to the facility, and updated quarterly during the care conference meetings. 5. On February 7, 2019, at 10:05 a.m., Resident 38's record was reviewed with the Social Service Director (SSD). Resident 38 was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive disease that affects memory and other important mental functions. Resident 38's face sheet information indicated he was self-responsible (had the ability to understand and make medical decisions for himself). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The records indicated Resident 38 signed the following documents in the Admission Packet when he was admitted to the facility (all dated on September 11, 2018): - Nursing Facilities Privacy Act Statement- Health Care Records; - Readmission Agreement; - Assignment of Insurance Benefits; - Patient Authorization to Bill; - Consent to Treat; - Medi-Cal Long-Term Care Facility Admission and Discharge Notification; - Appointment of Representative; - Bedhold Consent; and - Advance Directives/Medical Treatment Decisions. The following record of History and Physicial Examination completed by the physician was reviewed: - The History and Physical (H&P) dated September 5, 2018, indicated the H&P was not done because the resident left within 72 hours of admission; - The H&P dated September 11, 2018, indicated Resident 38 was readmitted to the facility, after being sent out to the acute hopital due to complaints of severe pelvic pain. In addition, The H&P indicated Resident 38 had a dignosis of senile dementia and he had the capacity to understand and make medical decisions; - The H&P dated September 25, 2018, indicated Resident 38 was readmitted again to the facility after an acute hospital stay due to a change in health condition. In addition, The H&P indicated Resident 38 could make needs known but could not make medical decisions due to the diagnoses of vascular dementia (type of dementia caused by multiple strokes); and - The H&P dated December 6, 2018, indicated Resident 38 was readmitted again to the facility after being transferred to the acute hospital in November 26, 2018, due to a worsening abdominal pain. In addition, The H&P indicated Resident 38 can make needs known but can not make medical decisions due to the diagnosis of vascular dementia. In a concurrent interview, the SSD stated Resident 38 did not have the capacity to make medical decisions for himself. The SSD stated the facility should have reviewed and updated the information as soon as the physician determined he was unable to make medical decisions in September 25, 2018. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The SSD stated the documents Resident 38 had signed on September 11, 2018, including the Consent to Treat and the Advance Directives/Medical Treatment Decisions, were all invalid because he was not capable of making medical decisions. The SSD stated when the physician had determined that Resident 38 did not have the capacity to make medical decisions, the facility should have made attempts to locate family members and apply for conservatorship (a guardian or protector appointed by the judge to manage financial affairs and and/or daily life of another due to physcial or mental limitations). The SSD stated there was no documented evidence these attempts were done for Resident 38. 37537 6. On February 12, 2019, Resident 276's record was reviewed. Resident 276 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's Disease (progressive mental deterioration). Resident 276 was admitted to the facility under hospice care (end of life care). The completed Physician's order for Life Sustaining Treatment (POLST) dated November 7, 2018, completed in the hospital by two physcians, indicated Resident 276 had no Advance Directive (AD - a written statement regarding a person's wishes regarding medical care). The interdisciplinary team (IDT) in the facility became Resident 276's responsible party on November 8, 2018. On February 12, 2019 at 8:13 a.m., an interview was conducted with the Social Services director (SSD). The SSD stated Resident 276 was admitted from the hospital on hospice. The SSD firther stated the resident had no family, no AD nor a documented evidence the facility applied for conservatorship. The SSD confirmed the facility should have applied for conservatorship. On February 13, 2019, at 1:44 p.m., Social Services (SS1)was interviewed. SS1 stated when a resident was admitted to the facility with no family member and no capacity to make medical decisions, the IDT should apply for conservatorship. 32191 7. On February 4, 2019, at 3:43 p.m., Resident 155's record was reviewed with Social Services (SS) 2. Resident 155 was admitted to the facility on [DATE]. Resident 155's latest History and Physical examination form, completed by the physician, dated March 3, 2018, indicated Resident 155 could make needs known but could not make medical decisions. Resident 155's records indicated his brother was the Responsible Party (RP). In a concurrent interview, SS 2 stated there was no documented evidence an AD was initiated and/or discussed with Resident 155's RP upon his admission to the facility. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SS 2 stated the SSD or Admissions Coordinator should have discussed the AD with Resident 155's RP upon his admission to the facility, and updated quarterly during the care conference meetings. On February 11, 2019, at 12:01 p.m., SSD 2 confirmed and acknowledged Resident 155 did not have an AD. SS 2 further stated resident should have an AD. The policy facility's policy and procedure dated December 2016, titled, APPOINTING A RESIDENT REPRESENTATIVE, was reviewed.The policy indicated . If the resident is determined to be incompetent under the laws of the State by a court of competent jurisdiction, the rights of the resident will devolve to and will be exercised by the resident representative appointed to act on the resident's behalf . The facility's policy and procedure dated January 2018, titled, ADVANCE DIRECTIVES, was reviewed. The policy indicated . Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so . If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative . Each resident will also be informed that the facility's policies do not condition the provision of care or discriminate against an individual based on wether or not the individual has executed an advance directive . Prior to or upon admission of a resident , the Social Services Director or designee will inquire of the resident , his/her family members and/or his or her legal representative, about the existence of any advance directives . If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36684 Based on observation, interview, and record review, the facility failed to ensure for one of 40 residents reviewed (Resident 38), privacy and/or dignity was provided when Resident 38 was observed from the hallway, lying in bed, uncovered, and half naked from his waist down. This failure resulted in Resident 38 to not maintain his dignity and enhance his quality of life. Findings: On February 4, 2019, the following observations were conduncted on Resident 38: - At 10 a.m., Resident 38 could be seen from the hallway outside his room. Resident 38 was in B bed and appeared to be restless. The privacy curtain on his right side partially covered the upper half of his body. Resident 38 was observed uncovered from his waist down. Resident 38 was wearing a disposable incontinence pad. Resident 38's foley catheter (flexible tube that passes through the urethra and into the bladder to drain urine) tube was secured to his right leg. Multiple staff members and other residents were observed passing by outside Resident 38's room during the observation.; and - At 10:05 a.m., the Restorative Nursing Assistant (RNA) 1, was observed passing water pitchers in the hallway. RNA 1 knocked and entered Resident 38's room and went to Bed A then RNA 1 stepped out of the room and proceeded to pass water pitchers to the next room. RNA 1 was not observed to have talked to Resident 38 while he was in the room, nor had he pulled the curtain over to provide privacy to the resident. Resident 38 continued to be seen from the hallway outside his room, and his lower body was still uncovered. On February 4, 2019, at 10:08 a.m., RNA 1 was interviewed outside of Resident 38's room. RNA 1 was asked if he noticed anything on Resident 38 when he went in the room to pass the water pitchers. RNA 1 stated he did not notice anything. RNA 1 then looked into Resident 38's room from the hallway, went in and pulled the curtain to provide privacy to the resident. RNA 1 stated he should have asked what the resident needed, and have pulled the curtain over earlier when he entered Resident 38's room to provide privacy to the resident who was in bed uncovered. On February 4, 2019, at 10:12 a.m., an observation and an interview was conducted with Licensed Vocational Nurse (LVN) 8 on Resident 38. Resident 38 was in bed, alert, appeared restless, and was still uncovered from his waist down. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 8 spoke to Resident 38 in Spanish and asked if he needed anything. Resident 38 grimaced and stated he felt pain pointing over his penile area. LVN 8 then covered Resident 38 lower body with a sheet and stated she will ask his charge nurse if he had taken something for his pain. On February 4, 2019, Resident 38's record was reviewed. Resident 38 was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive disease affecting the memory and other important mental functions). The facility's policy and procedure titled, Resident Rights, dated January 2018, was reviewed. The policy indicated, Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility.These rights include the resident's right to .a dignified existence .

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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** 32191 Based on observation, interview, and record review, the facility failed to ensure, for three of 40 sampled residents (Resident 155, 172, and 4), an accurate admission assessment was conducted. This failure resulted to the facility to not provide the necessary care and treatment appropriate for the resident. Findings: 1. On February 3, 2019, at 9:42 a.m., Resident 155's was observed lying in bed alert and oriented. Resident 155 stated his vision got worse and he was not able to see. On February 4, 2019, at 3:43 p.m., Resident 155's records were reviewed with the Minimum Data Set (MDS - an assessment tool) Nurse (MDSN). Resident 155 was admitted to the facility on [DATE], with diagnoses that included blindness on left eye and low vision on the right eye. The Quarterly MDS dated [DATE], indicated, Resident 155 had impaired vision. On February 4, 2019, at 11:12 a.m., an interview and observation was conducted with Director of Nursing (DON) 2, the Social Services Director (SSD), and the MDSN. Resident 155 stated the nurses needed to identify and tell him the location of his food on the meal tray before he could eat. DON 2, the SSD and the MDSN, acknowledged Resident 155 was unable to see because his vision got worsed. On January 9, 2019, DON 1 confirmed Resident 155's MDS dated [DATE], was inaccurate. DON 1 further stated the MDS assessment for vision should have been coded highly impaired since Resident 155 could not see on both eyes. 2. On February 3, 2019, at 10:15 a.m., Resident 172 was observed lying in bed. Resident had contractures (muscle or tendon that shorten or tighten) on both lower extremities, no splint were applied. On February 4, 2019, at 3:11 p.m., Resident 172's records was reviewed with the Minimum Data Set (MSD - an assessment tool) Nurse (MDSN). Resident 172 was readmitted to the facility on [DATE], with diagnoses that included abnormalities of gait The Quarterly MDS dated [DATE], and January 17, 2019, indicated, Resident 172 had no impairment on Functional Limitation in Range of Motion (FLROM) to both upper and lower extremities. A review of the Joint Mobility Assessment (JMA) dated October 15, 2018, indicated, Resident 172 had minimal limitation on right and left fingers, and limitation on left and right knees. On February 6, 2019, at 2:02 p.m., an observation and interview was conducted with the Rehabilitation Director (RD). The RD acknowledged and confirmed Resident 172 had limitation on both fingers and both knees. The RD further stated the MDS assessment conducted on October 17, 2018, and January 17, 2019, the FLROM should have indicated Resident 172 had limitations on both upper and lower extremities. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 11, 2019, at 11:29 a.m., the MSDN was interviewed. The MDSN confirmed and acknowledged the MDS assessment for FLROM were inaccurate. The CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) October 2017 Version 3.0 Manual, Chapter 3 Section I indicated: .The Items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, . One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status . 39503 3. On February 6, 2019, at 4:00 p.m., a concurrent observation and interview was conducted with the Minimum Data Set (MDS - an assessment tool) Nurse (MDSN). Resident 4 was lying in bed, his right arm was straightened and stiff with wrist contracture (shortening of the muscle and joint) and his left arm was bent and stiff. The MDSN stated Resident 4's right arm was impaired with contracture. The MDSN tried to help Resident 4 to move and straightened his left arm. Resident 4's left arm was so stiff and could not move or straighten it. The MDSN stated Resident 4's upper extremities were both impaired. Subsequently, Resident 4's record review was conducted with the MDSN. Resident 4 was admitted to the facility on [DATE], with diagnoses that included muscle weakness. Resident 4's MDS Quarterly assessment dated [DATE], indicated Resident 4's upper extremity had impairment on one side only. The MDSN stated the MDS assessment for Resident 4's upper extremity was inaccurate. The MDSN stated the impairment on upper extremities should have been documented as both sides instead of one side only. The MDSN stated she should have coordinated with the Rehabilitation Department for Resident 4's range of motion condition to make an accurate MDS assessment of Resident 4's impairment of upper extremities. The facility's policy and procedure titled, Resident Assessment Instrument Process (RAI), dated January 2018, was reviewed. The policy indicated, .The Resident Assessment Instrument (RAI) is used at the facility to provide the caregiving staff with ongoing assessment information necessary to develop a resident care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status . The RAI is completed by an interdisciplinary team . Each member of the interdisciplinary team reviews the entire MDS for accuracy .

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32191 Based on observation, interview, and record review, the facility failed to ensure the services being provided meet professional standards of practice for five of 40 residents reviewed (Residents 172, 157, 89, 4 and 129), when: 1a. For Resident 157's peripherally inserted central catheter (PICC - a kind of intravenous access) was not monitored and provided PICC line care since it was used on December 27, 2018; 1b. For Resident 172, the facility failed to ensure the Registered Nurse (RN) signed the electronic Medication Adminstration Record (eMAR) to indicate the intravenous (IV - into the veins) medication was administered to the residnet on January 11, 2019. In addition, the RN who made a late entry signature on the eMAR was not able to confirm if the IV meidcation was administered to the resident; 2. For Residents 89 and 4, the facility failed to ensure the RN sign the eMAR to indicate the IV medication was administered to the residents on multiple occasions in the month of Januaray 2019 and February 2019. In addition, the RN who made a late entry signature on the eMAR was not able to confirm if the IV meidcation was administered to the resident; and 3. For Resident 129, the licensed nurse did not sign the eMAR to indicate the medication was administered on January 25, 2019. These failures had increased the potential not to meet and provide the necessary care and services needed for the residents. Findings: 1a. On February 3, 2019, at 10:19 a.m., an observation was conducted with Registered Nurse (RN) 3. Resident 157 was observed lying in bed with a PICC line in the left upper arm. Resident 157's PICC line site had a dried blood covered with an unlabeled transparent dressing. On February 4, 2019, at 8:46 a.m., RN 3 was interviewed. RN 3 stated after the antibiotic therapy was completed the licensed nurse should have called the physician to ask if the PICC line needed to be discontinued. RN 3 stated the PICC LINE dressing should have been change every seven days using a complete sterile procedure with the label date the dressing was changed. RN 3 stated the PICC line site should have been monitored for signs and symptoms of infiltration and infection every shift. On February 7, 2019, Resident 157's record was reviewed with Director of Nursing (DON) 2. Resident 157 was admitted to the facility on [DATE], with diagnoses that included pneumonia (lung infection) and severe sepsis (infection). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 157 physician's order dated December 28, 2018, indicated, . Zosyn Solution Reconstituted 3.375 gram .use 3.375 gram intravenously every six hours for pneumonia for 7 days . The Care Plan dated December 28, 2019, indicated, Focus: Monitor Picc Line to the left upper arm. Goal . Free from complication to Picc Line site. Interventions: Change dressing to Picc Line every seven days as ordered. Flush and maintain patency of Picc Line. Monitor Picc line for sign and symptom of infection. Notify MD of any changes . There was no documented evidence the PICC line care was provided nor the PICC line was monitored for signs and symptoms of infection. In addition, there was no documented evidence a PICC line care was ordered by the physician. On February 7, 2019, at 9:36 a.m., a record review and interview was conducted with DON 1. DON 1 stated Resident 157's IV medication was completed on January 4, 2019. DON 1 stated after the IV therapy completion the licensed nurse should have called the physician to ask if the PICC LINE needed to be removed. DON 1 further stated the PICC LINE dressing should have been labeled with a date, time and initial of the nurse who changed the dressing. The DON stated the PICC line should have been monitored for any signs and symptoms of infection. The DON further stated the PICC line monitoring should have been ordered and monitored by the licensed nurses as it could lead to an infection. The facility's policy and procedure titled, IV Monitoring, dated July 26, 2010, was reviewed. The policy indicated, .Patients receiving infusion therapy will be monitored at established intervals based on prescribed therapy, and age and condition of patient Parameters to be monitored will be .IV site dressing .insertion site . 1b. On February 5, 2019, Resident 172's record was reviewed. Resident 172 was readmitted to the facility on [DATE]. Resident 172 physician's order dated January 3, 2019, indicated, .Merrem (antibiotic for infection) Solution Reconstituted 1 gram (GM) intravenously every eight hours for pneumonia (lung infection) for 10 days . Resident 172's eMAR for the month of January 2019, did not have a signature to indicate the IV antibiotic Merrem was administered on January 11, 2019, at 10 p.m. On February 7, 2019, at 4 p.m., RN 4 was interviewed. RN 4 stated she was the RN schedule for the evening shift on January 11, 2019. RN 4 stated she left early that day and she did not administer the IV medication Merrem to Resident 172. RN 4 further stated she had asked RN 2 to administer Resident 172's IV Merrem on January 11, 2019, for the 10 p.m. dose. RN 4 confirmed she made a late entry in the eMAR on February 7, 2019, and signed for the IV medication Merrem on January 11, 2019, at 10 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN 4 stated she was asked by the facility to do a late entry. RN 4 acknowledged and confirmed she did not administer the IV [NAME] on January 11, 2019, for the 10 p.m. dose, however, she still signed a late entry on the eMAR to indicate she administered the IV medication to Resident 172. On February 7, 2019, at 4:31 p.m., RN 2 was interviewed. RN 2 stated he was not sure if he was asked by RN 4 to administer the IV Merrem to Resident 172 on January 11, 2019. RN 2 stated he tried to sign the eMAR after he administered the medication to the resident or before the end of his shift. RN 2 confirmed he administered the IV Merrem but he did not sign the eMAR on January 11, 2019, at 10 p. m. to indicate it was adminsitered to Resident 172. RN 2 had no documented evidence the IV Merrem was administered to Resident 172 on January 11, 2019, at 10 p.m. 39503 2a. On February 5, 2019, at 2:46 p.m., Resident 89's record review was conducted with Director of Nursing (DON) 2. Resident 89 was readmitted to the facility on [DATE], with diagnosis that included urinary tract infection (UTI). Resident 89's physician's order indicated the following: - On January 28, 2019, Zosyn 3.375 gram to be given IV every eight hours for UTI. - On January 29, 2019, Fluconazole 200 milligram (mg) to be given IV once a day for UTI. Resident 89's eMAR for the month of January 2019, indicated the IV antibiotic Zosyn did not have a signature to indicate it was administered to the resident on January 28, 2019, at 10 p.m. and January 30, 2019, at 6 a.m. Resident 89's eMAR for the month of February 2019, indicated the following IV antibiotics: - Zosyn did not have a signature indicating it was administered to the resident on February 1, 2019, at 6 a.m. and 2 p.m.; and - Fluconazole did not have a signature indicating it was administered to the resident on February 1, 2019, at 9 a.m. On February 7, 2019, at 4:22 p.m., RN 1 was interviewed. RN 1 verified she was the RN assigned to give IV antibiotics on January 28, 2019, evening shift (3 p.m. to 11:30 p.m.) RN 1 verified Resident 89's eMAR for the month of January 2019 did not have her signature on IV antibiotic Zosyn to indicate it was administered to the resident on January 28, 2019, at 10 p.m. RN 1 verified there was no documented evidence the IV antibiotic Zosyn was given to Resident 89 on January 28, 2019, at 10 p.m. as ordered. RN 1 verified she made a late entry of signing the eMAR for January 28, 2019, at 10 p.m. for the IV antibiotic she did not sign. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN 1 stated she forgot to signed the eMAR but she administered the IV antibiotic Zosyn to Resident 89. RN 1 stated the IV antibiotic Zosyn she administered to the resident was from the discontinued medications stored in the medication room. On February 12, 2019, at 8:40 a.m., RN 2 was interviewed. RN 2 verified he was the RN assigned to give IV antibiotics on January 30, 2019 and February 1, 2019, night shift (11 p.m. to 7:30 a.m.) RN 2 verified Resident 89's eMAR did not have his signature on IV antibiotic Zosyn to indicate it was administered to the resident on January 30, 2019, at 6 a.m. and February 1, 2019, at 6 a.m. RN 2 verified there was no documented evidence the IV antibiotic Zosyn was given to Resident 89 on January 30, 2019, at 6 a.m. and February 1, 2019, at 6 a.m. as ordered. RN 2 verified he made a late entry on February 5, 2019, by signing the eMAR for January 30, 2019, at 6 a.m. and February 1, 2019, at 6 a.m. on the IV antibiotic he did not sign. RN 2 stated he should have signed the eMAR after each administration of the medication to the resident. RN 2 further stated he could not remember if the antibiotics were given or not to Resident 89 on the dates he did not sign. RN 2 stated he was told by the facility that he missed signing the eMAR so he made a late entry. RN 2 further stated he was not sure for the late entry signature he made if the IV antibiotic Zosyn was administered to Resident 89. On February 12, 2019, at 8:56 a.m., RN 3 was interviewed. RN 3 verified she was the RN assigned to give IV antibiotics on February 1, 2019, day shift (7 a.m. to 3:30 p.m.) RN 3 verified Resident 89's eMAR for the month of February 2019, had the following IV antibiotics: - Zosyn did not have her signature to indicate it was administered to the resident on February 1, 2019, at 2 p. m.; and - Fluconazole did not have her signature to indicate it was administered to the resident on February 1, 2019, at 9 a.m. RN 3 verified there was no documented evidence the IV antibiotic Zosyn and Fluconazole was administered to Resident 89 on February 1, 2019, at 9 a.m. and 2 p.m. RN 3 verified she made a late entry on February 6, 2019, by signing the eMAR on February 1, 2019, at 9 a. m. and 2 p.m. for IV antibiotics she did not sign. RN 3 stated she should have signed the eMAR after each administration of the medication to the resident. RN 3 further stated she could not remember if the antibiotics were given or not to Resident 89 on the dates she did not sign. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN 3 stated she received her eMAR audits from the medical records with the missing signature. RN further stated she just wanted to fix her audits and made sure there was nothing missing on Resident 89's eMAR. 2b. On February 5, 2019, at 2:46 p.m., Resident 4's record review was conducted with Director of Nursing (DON) 1. Resident 4 was readmitted to the facility on [DATE], with diagnosis that included urinary tract infection (UTI). Resident 4's physician's order indicated the following: - on January 29, 2019, Meropenem (Merrem) one gram to be given IV every eight hours for UTI. - on January 30, 2019, Vancomycin 750 milligram (mg) to be given IV every eight hours for UTI. Resident 4's eMAR for the month of January 2019, indicated the IV antibiotics Vancomycin and Merrem did not have a signature to indicate it was administered to the resident on January 30, 2019, at 6 a.m. Resident 4's eMAR for the month of February 2019, indicated the IV antibiotics Vancomycin and Merrem did not have a signature to indicate it was administered to the resident on February 1, 2019, at 6 a.m. and 2 p.m. On February 12, 2019, at 8:40 a.m., a concurrent record review and interview was conducted with RN 2. RN 2 verified he was the RN assigned to give IV antibiotics on January 30, 2019 and February 1, 2019, night shift (11 p.m. to 7:30 a.m.). RN 2 verified he did not sign Resident 4's eMAR on January 30, 2019, at 6 a.m. and February 1, 2019, at 6a. m. to indicate the IV antibiotics Vancomycin and Merrem were administered to the resident. RN 2 verified there was no documented evidence the IV antibiotics Vancomycin and Merrem were given on those dates as ordered. RN 2 verified he made a late entry on February 5, 2019, by signing the eMAR for January 30, 2019, at 6 a.m. and February 1, 2019, at 6 a.m. for the IV antibiotics he did not sign. RN 2 stated he should have signed the eMAR after each administration of the medication to the resident. RN 2 further stated he could not remember if the antibiotics were given or not to Resident 4 on the dates he did not sign. RN 2 stated he was told by the facility that he missed signing the eMAR so he made a late entry. RN 2 further stated he was not sure for the late entry signature he made if the IV antibiotics were administered to Resident 4. RN 2 stated for Resident 4's IV antibiotic Vancomycin, he may have used the medication from the discontinued medication or he may have borrowed from another resident that was on IV antibiotic Vancomycin. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On February 12, 2019, at 8:56 a.m., a concurrent record review and interview was conducted with RN 3. RN 3 verified she was the RN assigned to give IV antibiotics on February 1, 2019, day shift (7 a.m. to 3:30 p.m.). RN 3 verified she did not sign Resident 4's eMAR on February 1, 2019, at 2 p.m., to indicate the IV antibiotic Vancomycin and Merrem were administered to the resident. RN 3 verified there was no documented evidence the IV antibiotic Vancomycin and Merrem were given on February 1, 2019, at 2 p.m. as ordered. RN 3 verified she made a late entry on February 6, 2019, by signing the eMAR on February 1, 2019 at and 2 p.m. for IV antibiotics she did not sign. RN 3 stated if she did not sign the eMAR it meant the medication was not available or she did not administer it. RN 3 further stated she could not remember if the antibiotics were given or not to Resident 4 on the dates she did not sign. RN 3 stated she received her eMAR audits from the medical records with the missing signature. RN further stated she just wanted to fix her audits and made sure there was nothing missing on Resident 4's eMAR. The undated facility's policy and procedure titled, DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES, was reviewed. The policy indicated, .When medications are discontinued by a prescriber .the medications are marked as discontinued and destroyed .Medications are removed from the medication cart immediately upon receipt of an order to discontinue (to avoid inadvertent administration) . The facility's policy and procedure titled, Documentation of Principle, dated January 2014, was reviewed. The policy indicated, .Complete Entries - Entries must be Accurate; Timely - recorded within the required time period; Objective - record facts and what it is, do not assume . 36684 3. On February 7, 2019, Resident 129's record was reviewed. Resident 129 was admitted to the facility on [DATE], with diagnoses that included chronic pain syndrome, hypercholesterolemia (high level of cholesterol in the blood), and Chronic Obstructive Pulmonary Disease (COPD- type of lung disease). The January 2019 eMAR indicated Resident 129 was scheduled to receive the following medications at 9 p. m. daily: - Advair Diskus (medication used to treat COPD) 250-50 MCG(microgram)/dose to be inhaled one puff orally (date ordered February 27, 2016); - Atorvastatin Calcium (medication used to treat hypercholesterolemia) 10 mg (milligrams) one tablet by mouth (date ordered February 27, 2016); - Pamelor Capsule (a nerve pain medication) 25 mg to be given one capsule by mouth (date ordered February 27, 2016); (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Vitamin D3 tablet (supplement) 1000 unit 1 tablet by mouth (date ordered January 23, 2018); and - Morphine Sulfate tablet (pain medication) 30 mg one tablet by mouth. There was no documented evidence in the January 2019 eMAR the licensed nurse administered these medications to Resident 129 on January 25, 2019, at 9 p.m. On February 12, 2019, at 8:45 a.m., Resident 129's record was reviewed with Licensed Vocational Nurse (LVN) 10. LVN 10 stated he was the licensed nurse assigned to administer the medications to Resident 129 on January 25, 2019, in the evening shift. LVN 10 stated he remembered giving the medications: Advair, Atorvastatin Calcium, Pamelor, Vit D3, and Morphine tablet, to Resident 129 on Janauary 25, 2019, at 9 p.m. but he forgot to sign the eMAR after administering the medications. LVN 10 stated he probably got busy or something had come up at that time and he forgot to sign the eMAR after giving the medications to her. LVN 10 stated the facility's procedure was to sign the eMAR after the medication administration on a resident. LVN 10 stated he should have signed the eMAR after administering these medications to Resident 129. The facility's policy and procedure titled Administering Medications, dated January 2018, was reviewed. The policy indicated, .Medications shall be administered in a safe and timely manner, and as prescribed .The individual administering the medication must initial the resident's MAR after giving each medication and before administering the next ones .As required or indicated for a medication, the individual administering the medication will record in the resident's medical record .The signature and title of the person administering the drug .

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39503 Based on observation, interview, and record review, the facility failed to ensure 12 of 40 residents reviewed (Residents 77, 89, 4, 47, 129, 277, 43, 155, 172, 157, 83, and 154) received treatment and care in accordance with professional standards of practice and the comprehensive care plan when: 1. Resident 77 did not receive her first dose of Indomethacin (medication for pain) as ordered by the physician. In addition, Resident 77's left hand swelling and pain was not addressed and reported to the physician in a timely manner. This failure resulted in the resident experiencing increased pain. 2. Resident 89, did not receive her intravenous (IV - into the veins) antibiotics (Zosyn and Fluconazole) on multiple occasions for treatment of urinary tract infection (UTI). In addition, Resident 89 may have received discontinued IV antibiotic medication. This failure could jeopardize the resident's health and safety for not treating the UTI appropriately that could result into complications such as kidney damage. In addition, the resident could have received expired or inaccurate medication dosages from the possible use of discontinued medications. 3a. Resident 4, did not receive his IV antibiotics (Merrem and Vancomycin) on multiple occasions for treatment of UTI. In addition, Resident 4 may have received discontinued IV antibiotic medication. This failure could jeopardize the resident's health and safety for not treating the UTI appropriately that could result into complications such as kidney damage. In addition, the resident could have received expired or inaccurate medication dosages from the possible use of discontinued medications. 3b. Resident 4's right hand edema (swelling caused by fluid in the body tissue) was not addressed and reported to the physician since it was identified on [DATE]. This failure may result in further potential problems and complications in the resident's medical condition. 3c. Resident 4's bilateral hand and knee splints were not provided since the Physical Therapy (PT - healthcare specialty that evaluate and treat individuals with limitation in functional mobility) evaluation on [DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	This failure may result in further potential decline in the resident's range of motion. 4. Resident 47's bilateral foot drop (difficulty in lifting the front part of the foot) splints were not provided since [DATE]. This failure may result in further potential decline in the resident's range of motion. 5. Resident 129 did not receive her routine medication Norco (narcotic pain medication) on multiple occasions for the month of [DATE]. This failure resulted in the resident experiencing increased pain. 6. Resident 277 did not receive her routine medication Fiorinal (a narcotic pain medication used for migraine - intense headache and sensitivity to light) on multiple occasions for the month of [DATE]. This failure resulted in the potential for the resident to experience excessive migraine headaches. 7. Resident 43's open wound on the left side of the abdomen was not addressed and reported to the physician since it was identified on February 3, 2019. This failure may result in further potential problems and complications in the resident's medical condition. 8. Resident 155 did not receive three doses of a new physician's order of Tramadol (narcotic pain medication). This failure resulted in the resident experiencing increased pain. 9. Resident 172 did not receive her routine medication Alprazolam (medication for anxiety) from [DATE] to 22, 2019. This failure put the resident at risk to experience increased anxiety. 10. Resident 172 did not receive her IV antibiotic Vancomycin for treatment of her pneumonia (lung infection). This failure could jeopardize the resident's health and safety for not treating the pneumonia that could result into complications such as respiratory failure and death. 11. Resident 157's peripherally inserted central catheter (PICC - a kind of intravenous access) was not monitored and provided PICC line care since it was used on [DATE]. This failure may result in further potential problems and complications in the resident's medical condition such as infection. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	12. Resident 83's cloudy urine with sedimentation (particles in the fluids) from the Foley Catheter (FC - a flexible tube that passes through the urethra and into the bladder to drain urine) was not addressed and reported to the physician. This failure may result in further potential problems and complications in the resident's medical condition such as urinary infection. 13. Resident 154 did not receive his routine medication Albuterol (medication for chronic obstructive pulmonary disease {COPD - lung disease that block the airflow and make it difficult to breathe}) on multiple occasions at night when the resident was asleep from [DATE] to February 2019. This failure could jeopardize the resident's health and safety for not managing and treating the COPD that could result into complications like respiratory failure and death. 14. Resident 154 did not receive his routine medications (Neurontin - medication for neuropathy {pain from nerve damage}; Lipitor - medication for high cholesterol level; Risperdal - medication for schizophrenia {mental disorder}; and Protonix - medication for acid reflux) on multiple occasions for the month of [DATE]. This failure could jeopardize the resident's health and safety for not managing and treating the medical conditions, overall long-term health and well-being of the resident. Findings: 1. On February 3, 2019, at 11:49 a.m., Resident 77 was observed sitting in her wheelchair, with facial grimacing, was moaning and massaging her left hand. Resident 77 stated her left hand was hurting. She showed her left hand, and the area around the left thumb was swollen. Resident 77 stated it had been swollen and hurting for a week now. She further stated she was in a lot of pain last night, she cried and she was not able to sleep because of too much pain. Resident 77 stated her nurse did not give her anything for pain last night and told her she was waiting for the pharmacy to deliver the pain medication ordered by the physician. On February 5, 2019, at 11:06 a.m., a concurrent record review and interview was conducted with Licensed Vocational Nurse (LVN) 2. Resident 77 was admitted to the facility on [DATE], with diagnosis that included neuritis (inflammation of a peripheral nerve usually causing pain). Resident 77's physician's order dated February 2, 2019, at 9:22 a.m., indicated Indomethacin 50 milligram (mg) to give one capsule by mouth three times a day for inflammation (swelling). A physician's order dated [DATE], indicated Tylenol (pain medication) 650 mg to be given by mouth every six hours as needed for pain. (continued on next page)

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Riverside Postacute Care	8781 Lakeview Avenue Riverside, CA 92509

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Resident 77's electronic Medication Record Administration (eMAR) for February 2019, indicated the medication Indomethacin was not administered on February 2, 2019, at 5 p.m., and indicated 9 (facility chart codes 9 = other/see progress notes) as a reason. In addition, the eMAR did not indicate Resident 77 was offered non-pharmacological interventions nor was given the Tylenol for pain on February 2, 2019. Resident 77's progress notes dated February 2, 2019, at 7:31 p.m., indicated awaiting delivery for the medication Indomethacin. LVN 2 stated when she was the charge nurse for Resident 77 last week ([DATE] to February 2, 2019) the resident had complained of swelling and pain on her left hand. LVN 2 verified there was no documented evidence Resident 77's left hand swelling and pain were addressed nor the physician notified on the week the resident complained. LVN 2 verified there was no documented evidence a care plan was developed addressing Resident 77's left hand swelling and pain. LVN 2 stated when she came back from two days off from work (February 2, 2019) Resident 77's left hand was still swollen and the resident still complained of pain. LVN 2 further stated she called and notified the physician and received an order for Resident 77 to be started on Indomethacin for left hand swelling and pain. She stated she did not know why it was not addressed last week when Resident 77 started to have swelling and pain on the left hand. LVN 2 stated the Indomethacin should have been delivered in the afternoon by the pharmacy since it was ordered on the morning of February 2, 2019. LVN 2 stated she did not call the pharmacy to inquire for the time of delivery of the medication. LVN 2 further stated the nurse from the evening shift should have called the pharmacy to follow up. LVN 2 confirmed Resident 77 was in pain on February 2, 2019. LVN 2 stated she should have offered non-pharmacological interventions or gave the Tylenol to Resident 77 for pain management while waiting for the Indomethacin to be delivered. On February 5, 2019, at 2:22 p.m., Director of Nursing (DON) 2 was interviewed. DON 2 stated the pharmacy delivery of medications in the facility were daily, three times a day. DON 2 stated if there was a change of condition in the resident, the licensed nurse should have done an assessment, notified the physician, and developed a care plan. DON 2 stated, for new medication orders especially for pain, the nurse should have called the pharmacy, to inquire for the time of delivery, to ensure the medication would be available for administration. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	DON 2 stated Resident 77 should have been offered non-pharmacological interventions or given the Tylenol for pain while waiting for the Indomethacin to be delivered. The undated facility policy and procedure titled, MEDICATION ORDERING AND RECEIVING FROM PHARMACY, was reviewed. The policy indicated, .New medications .If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery and request delivery within (4) hours .Timely delivery of new orders is required so that medication administration is not delayed . The facility policy and procedure titled, Changes in Resident Condition, dated [DATE] was reviewed. The policy indicated, .a significant change in the resident's physical, mental or psychosocial status; The SBAR (Situation, Background, Assessment, Recommendation) in EHR (electronic health record); a communication note utilized to assess and document changes in condition .provide assessment information to physician . Changes in condition are communicated from shift to shift through the 24 hour report management system . Changes in the resident status that affect the problem(s)/goal(s) or approach(es) on his/her care plan are documented as revisions and communicated to the interdisciplinary caregivers . 2. On February 5, 2019, at 2:46 p.m., Resident 89's record review was conducted with Director of Nursing (DON) 2. Resident 89 was readmitted to the facility on [DATE], with diagnosis that included UTI. Resident 89's physician's order indicated the following: - on [DATE], Zosyn 3.375 gram to be given IV every eight hours for UTI. - on [DATE], Fluconazole 200 milligram (mg) to be given IV once a day for UTI. Resident 89's electronic Medication Administration Record (eMAR) for the month of [DATE], indicated: - IV antibiotic Zosyn did not have a signature to indicate it was administered to the resident on [DATE], at 10 p.m. and [DATE], at 6 a.m. Resident 89's eMAR for the month of February 2019, indicated: - IV antibiotic Zosyn did not have a signature indicating it was administered to the resident on February 1, 2019, at 6 a.m. and 2 p.m.; and - IV antibiotic Fluconazole did not have a signature indicating it was administered to the resident on February 1, 2019 at 9 a.m. On February 7, 2019, at 4:22 p.m., Registered Nurse (RN) 1 was interviewed. RN 1 verified she was the RN assigned to give IV antibiotics on [DATE], evening shift (3 p.m. to 11:30 p.m.) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	RN 1 verified Resident 89's eMAR for the month of [DATE], did not have her signature on IV antibiotic Zosyn as indication it was administered to the resident on [DATE], at 10 p.m. RN 1 verified there was no documented evidence the IV antibiotic Zosyn was given to Resident 89 on [DATE], at 10 p.m. as ordered. RN 1 stated she forgot to signed the eMAR but she administered the IV antibiotic Zosyn to Resident 89. RN 1 stated Resident 89's IV antibiotic Zosyn was not available due to pharmacy delivery. She further stated the IV Zosyn she administered to the resident was from the discontinued medications stored in the medication room. RN 1 stated when an order of IV antibiotic for a resident was not available, the RNs in the facility would use, if it was available, discontinued IV antibiotic medications stored in the medication room. RN 1 further stated she was aware when a medication was not available, the licensed nurse should call the pharmacy to inquire for the availability of the medication or the licensed nurse should get a dose from the automated drug dispensing system (ADDS - computer controlled storage, dispensing and tracking of medications) when the medication was in stock and available for administration. RN 1 stated she did not call the pharmacy nor took a dose from the ADDS when Resident 89's IV antibiotic Zosyn was not available. RN 1 stated she used the IV Zosyn antibiotic from discontinued medication to administered to Resident 89 on [DATE], at 10 p.m. However, she was unable to provide documented evidence. On February 12, 2019, at 8:40 a.m., RN 2 was interviewed. RN 2 verified he was the RN assigned to give IV antibiotics on [DATE] and February 1, 2019, night shift (11 p.m. to 7:30 a.m.) RN 2 verified Resident 89's eMAR did not have his signature on IV antibiotic Zosyn to indicate it was administered to the resident on [DATE], at 6 a.m. and February 1, 2019, at 6 a.m. RN 2 verified there was no documented evidence the IV antibiotic Zosyn was given to Resident 89 on [DATE], at 6 a.m. and February 1, 2019, at 6 a.m. as ordered. RN 2 verified he made a late entry on February 5, 2019, by signing the eMAR for [DATE], at 6 a.m. and February 1, 2019, at 6 a.m., for IV antibiotic he did not sign as administered to the resident. RN 2 stated he should have signed the eMAR after each administration of the medication to the resident. RN 2 further stated he did not remember if the antibiotic was given or not to Resident 89 on the dates he did not sign. RN 2 stated he was told by the facility that he missed signing the eMAR so he made a late entry. RN 2 further stated he was not sure for the late entry signature he made if the IV antibiotic Zosyn was administered to the resident or not. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	On February 12, 2019, at 8:56 a.m., RN 3 was interviewed. RN 3 verified she was the RN assigned to give IV antibiotics on February 1, 2019, day shift (7 a.m. to 3:30 p.m.) RN 3 verified Resident 89's eMAR for the month of February 2019, had the following IV antibiotics order: - Zosyn did not have her signature to indicate it was administered to the resident on February 1, 2019, at 2 p. m.; and - Fluconazole did not have her signature to indicate it was administered to the resident on February 1, 2019, at 9 a.m. RN 3 verified there was no documented evidence the IV antibiotic Zosyn and Fluconazole were administered to Resident 89 on February 1, 2019, at 9 a.m. and 2 p.m. RN 3 verified she made a late entry on February 6, 2019, by signing the eMAR for February 1, 2019 at 9 a. m. and 2 p.m. for the IV antibiotics she did not sign as administered to the resident. RN 3 stated she should have signed the eMAR after each administration of the medication to the resident. RN 3 further stated she was not sure for the late entry signature she made if the IV antibiotics were administered to the resident or not. RN 3 stated she received her eMAR audits from the medical records with the missing signature. RN 3 further stated she just wanted to fix her audits and made sure there was nothing missing on Resident 89's eMAR. 3a. On February 5, 2019, at 2:46 p.m., Resident 4's record review was conducted with Director of Nursing (DON) 2. Resident 4 was readmitted to the facility on [DATE], with diagnosis that included UTI. Resident 4's physician's order indicated the following: - on [DATE], Meropenem (Merrem) one gram to be given IV every eight hours for UTI. - on [DATE], Vancomycin 750 milligram (mg) to be given IV every eight hours for UTI. Resident 4's electronic Medication Administration Record (eMAR) for the month of [DATE], indicated the IV antibiotics Vancomycin and Merrem did not have a signature to indicate it was administered to the resident on [DATE], at 6 a.m. Resident 4's eMAR for the month of February 2019, indicated the IV antibiotics Vancomycin and Merrem did not have a signature to indicate it was administered to the resident on February 1, 2019, at 6 a.m. and 2 p.m. On February 12, 2019, at 8:40 a.m., a concurrent record review and interview was conducted with RN 2. RN 2 verified he was the RN assigned to give IV antibiotics on [DATE] and February 1, 2019, night shift (11 p.m. to 7:30 a.m.). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	RN 2 verified he did not sign Resident 4's eMAR on [DATE], at 6 a.m., and February 1, 2019, at 6 a.m. to indicate the IV antibiotics Vancomycin and Merrem were administered to the resident. RN 2 verified there was no documented evidence the IV antibiotics Vancomycin and Merrem were given on those dates. RN 2 verified he made a late entry on February 5, 2019, by signing the eMAR for [DATE], at 6 a.m. and February 1, 2019, at 6 a.m. for IV antibiotics he did not sign as administered to the resident. RN 2 stated he should have signed the eMAR after each administration of the medication to the resident. RN 2 further stated he did not remember if the IV antibiotics were given or not to Resident 4 on the dates he did not sign. RN 2 stated he was told by the facility that he missed signing the eMAR so he made a late entry. RN 2 further stated he was not sure for the late entry signature he made if the IV antibiotics were administered to Resident 4 or not. RN 2 stated for Resident 4's IV antibiotic Vancomycin, he may have used the medication from the discontinued medication or he may have borrowed from another resident that was on IV antibiotic Vancomycin. However, he was unable to provide documented evidence of either. On February 12, 2019, at 8:56 a.m., a concurrent record review and interview was conducted with RN 3. RN 3 verified she was the RN assigned to give IV antibiotics on February 1, 2019, day shift (7 a.m. to 3:30 p.m.). RN 3 verified she did not sign Resident 4's eMAR on February 1, 2019, at 2 p.m., to indicate the IV antibiotic Vancomycin and Merrem were administered to the resident. RN 3 verified there was no documented evidence the IV antibiotic Vancomycin and Merrem were given on February 1, 2019, at 2 p.m. RN 3 verified she made a late entry on February 6, 2019, by signing the eMAR for February 1, 2019 at and 2 p.m. for IV antibiotics she did not sign as administered to the resident. RN 3 stated if she did not sign the eMAR it means the medication was not available or she did not administered it. RN 3 further stated she could not remember if the IV antibiotics were administered or not to Resident 4 on the dates she did not sign. RN 3 stated she received her eMAR audits from the medical records with the missing signature. RN 3 further stated she just wanted to fix her audits and made sure there was nothing missing on Resident 4's eMAR. The facility policy and procedure titled, Administering Medications, dated [DATE], was reviewed. The policy indicated, .Medications shall be administered in a safe and timely manner, and as prescribed .The individual administering the medication must initial the resident's MAR after giving each medication and before administering the next ones .Medications ordered for a particular resident may not be administered to another resident . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	The undated facility policy and procedure titled, DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES, was reviewed. The policy indicated, .When medications are discontinued by a prescriber .the medications are marked as discontinued and destroyed .Medications are removed from the medication cart immediately upon receipt of an order to discontinue (to avoid inadvertent administration) . The facility's policy and procedure titled, Documentation of Principle, dated [DATE], was reviewed. The policy indicated, .Complete Entries - Entries must be Accurate; Timely - recorded within the required time period; Objective - record facts and what it is, do not assume . 3b. On February 3, 2019, at 12:18 p.m., a concurrent observation was conducted with Licensed Vocational Nurse (LVN) 1. Resident 4 was observed lying down in bed, turned on his left side with both upper extremities were contracted (a muscle that shortened or tightened) and unable to move. Resident 4's right arm was straightened out with wrist contracture, the right hand was swollen, and not elevated on a pillow. Both hands had no splint or hand towel roll applied. On February 11, 2019, at 2:56 p.m., a concurrent record review and interview was conducted with the Assistant Director of Nursing (ADON). Resident 4 was readmitted to the facility on [DATE], with diagnoses that included muscle weakness. Resident 4's nursing admission assessment dated [DATE], indicated the resident had edema of the right hand. There was no documented evidence the physician was notified of Resident 4's right hand edema and a care plan was not developed since identified on [DATE]. The ADON stated Resident 4's right hand edema should have been addressed. The ADON further stated the licensed nurse should have notified the physician and should have developed a care plan. The facility policy and procedure titled, Changes in Resident Condition, dated [DATE] was reviewed. The policy indicated, .a significant change in the resident's physical, mental or psychosocial status; The SBAR (Situation, Background, Assessment, Recommendation) in EHR (electronic health record); a communication note utilized to assess and document changes in condition .provide assessment information to physician . Changes in condition are communicated from shift to shift through the 24 hour report management system . Changes in the resident status that affect the problem(s)/goal(s) or approach(es) on his/her care plan are documented as revisions and communicated to the interdisciplinary caregivers . 3c. On February 3, 2019, at 12:18 p.m., a concurrent observation was conducted with Licensed Vocational Nurse (LVN) 1. Resident 4 was observed lying down in bed, turned on his left side with both upper extremities contracted (a muscle that shortened or tightened) and unable to move. Resident 4's right arm was straightened out with wrist contracture, the right hand was swollen, and not elevated on a pillow. Both hands had no splint or hand towel roll applied. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	On February 11, 2019, at 11:11 a.m., a concurrent record review and interview was conducted with the Rehabilitation Director (RD). Resident 4 was admitted to the facility on [DATE], with diagnoses that included muscle weakness. Resident 4's, OT (Occupational Therapy) Evaluation & Plan of Treatment, dated [DATE], indicated, .Long-Term Goals .Patient will increase tolerance in wearing right hand resting splint to 4 hours to prevent decline and for contracture mgmt. (management) . Resident 4's, PT Evaluation & Plan of Treatment, dated [DATE], indicated, .Long-Term Goals .Patient will safely wear a knee extension splint on right knee and left knee for up to 6 hours . There was no documented evidence the splints for the right hand and bilateral knees were used and applied to Resident 4 since the PT and OT evaluation on [DATE]. The RD stated, the ordering of the splints for Resident's 4 right hand and bilateral knees were not followed up when the Resident 4 was transferred out to the hospital in [DATE]. The RD stated it should have been ordered and made sure it was available for Resident 4 to use when the resident came back to the facility. 4. On February 4, 2019, Resident 47 was observed lying in bed. Both lower extremities were noted with foot drop, and did not have a splint or brace applied on the resident's legs and feet. On February 11, 2019, at 1:15 p.m., a concurrent record review and interview was conducted with the Rehabilitation Director (RD). Resident 47 was admitted to the facility on [DATE], with diagnoses that included muscle weakness, muscle wasting and atrophy (decrease in size or wasting away of a body part). Resident 47's, PT Evaluation & Plan of Treatment, dated [DATE], indicated, .Long-Term Goals .Patient will safely wear a foot drop splint on the right foot and left foot for up to 6 hours . There was no documented evidence the foot drop splints were used and applied to Resident 47's feet since the resident was discharged from the PT services on [DATE]. On February 11, 2019, at 4 p.m., the Registered Physical Therapist (RPT) was interviewed. The RPT stated after the resident's discharge from PT services, a recommendation of what the resident would need for range of motion should be provided. The RPT stated Resident 47 needed the splints for her feet to prevent further decline or worsening of the foot drop. The RPT stated she forgot to include on her recommendation the need for ordering of the foot drop splints after discharging Resident 47 from PT services on [DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	36684 5. On February 7, 2019, Resident 129's record was reviewed. Resident 129 was admitted to the facility on [DATE], with diagnoses that included chronic pain syndrome. The physician's order dated [DATE], indicated to give Norco tablet ,d+[DATE] milligrams (mg) one tablet by mouth every six hours for pain management. The [DATE] electronic Medication Administration Record (eMAR), indicated the Norco medication was scheduled to be given at 12 a.m, 6 a.m., 12 p.m., and 6 a.m. In addition, the eMAR indicated Resident 129 did not receive the Norco tablet for pain on the following dates: - [DATE], at 6 p.m.; - [DATE], at 12 a.m.; and - [DATE], at 12 a.m. and 6 a.m. The corresponding Medication Administratuion Note for the dates Resident 129 did not receive her routine Norco medication for pain, indicated the licensed nurses were not able to give the medication because it was not available pending pharmacy delivery. On February 7, 2019, at 10:26 a.m., Licensed Vocational Nurse (LVN) 3 was interviewed. LVN 3 stated he was not able to administer the Norco medication to Resident 129 on [DATE], at 12 a.m. and 6 a.m., because the medication was not available. LVN 3 further stated there was a delay in the delivery of the medication from the pharmacy. On [DATE], at 10:33 a.m., an observation with a concurrent interview was conducted on Resident 129. Resident 129 was alert and was up in her wheelchair inside her room. Resident 129 stated she took the routine Norco medication to help manage her chronic pain syndrome. Resident 129 stated she remembered missing a couple of doses of her Norco medication in [DATE]. Resident 129 further stated the licensed nurses just kept telling her to wait at that time because it was going to be delivered soon. Resident 129 stated she waited but her Norco was not delivered on time and she missed some doses scheduled. Resident 129 stated she felt her body tense up with pain when she did not get her Norco pain medication as scheduled. Resident 129 stated this was not the first time she had missed her medications because it was not available. Resident 129 stated, I really did not appreciate that. 6. On February 7, 2019, at 9:30 a.m., Resident 277's record was reviewed. Resident 277 was admitted to the facility on [DATE], with diagnoses that included migraine. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	The physician's order dated [DATE], indicated to give Fiorinal capsule [DATE] milligrams (mg) to be given by mouth three times a day for migraine. The [DATE] electronic Medication Administration Record (eMAR) indicated the medication Fiorinal was scheduled to be given at 6 a.m., 2 p.m., and 10 p.m. daily. In addition, the eMAR indicated Resident 277 did not receive the medication Fiorinal on the following dates: - [DATE] at 6 a.m., 2 p.m., and 10 p.m.; - [DATE], at 6 a.m. and 10 p.m.; - [DATE], at 6 a.m. and 10 p.m.; and - [DATE], at 6 a.m., 2 p.m., and 10 p.m. The corresponding Medication Administration Note for the dates Resident 277 did not receive her routine Fiorinal medication for migraine, indicated the licensed nurses were not able to give the medication because it was not available pending pharmacy delivery. On February 7, 2019, at 10:44 a.m., an observation with a concurrent interview was conducted on Resident 277. Resident 277 was in bed, alert, and conversant. Resident 277 stated the doctor prescribed her the Fiorinal medication specifically to treat her bad migraine problem. Resident 277 stated she remembered missing doses of her Fiorinal medication in [DATE] because the medication was not available. Resident 277 stated this was not the first she had missed doses of her medication because of medication unavailability due to the delayed delivery of her medication from the pharmacy. Resident 277 stated she had been monitoring her medication supply because the licensed nurses let her medication ran out before they call the pharmacy for a refill. Resident 277 stated the Fiorinal was the only medication that helped her treat her bad migraine problem. On February 7, 2019, at 11:04 a.m., Licensed Vocational Nurse (LVN) 4 was interviewed. LVN 4 stated she was not able to administer Resident 277's Fiorinal medication on [DATE] at 2 p.m. and [DATE], at 2 p.m. LVN 4 further stated the Fiorinal medication was not administered because it was not available pending pharmacy delivery. LVN 4 stated there had been issues with the pharmacy regarding the delayed delivery of medications, which resulted in the residents not getting their medications on time as ordered by the physician. The facility's policy and procedure titled, Administering Medications, dated [DATE], was reviewed. The policy indicated, .Medications shall be administered in a safe and timely manner, and as prescribed . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	7. On February 3, 2019, at 9:44 a.m., an observation with an interview was conducted with Certified Nursing Assistant (CNA) 2 on Resident 43. Resident 43 was in bed, alert, and gave the permission to inspect her abdomen for a skin problem. CNA 2 lifted Resident 43's gown to expose her abdomen. On the left side of her abdomen near the stoma (surgically created opening between the intestine and the abdominal wall) site, was an open wound. The open wound had a moist red wound base and was approximately 2.5 by 2 cm (centimeter) in size. The wound edge was dry and slightly reddened. A type of a

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32191 Based on observation, interview, and record review, the facility failed to ensure an intravenous (IV - into the veins) care was provided for one of five residents reviewed (Resident 89) when the IV antibiotic tubing used on February 2, 2019, had a label discard date of February 1, 2019. This failure had the potential to put the residents at risk for further infection including hospitalization . Findings: On February 3, 2019, at 9:16 a.m., a concurrent observation and interview was conducted with Registered Nurse (RN) 5. Resident 89 was lying in bed, with an IV heplock (a catheter needle with a small piece of tube that an IV line can be hooked on it) on the left arm. On Resident 89's bedside was an IV pole hanging an empty Fluconazole (antibiotic for treatment of urinary tract infection {UTI}) IV antibiotic bag dated February 2, 2019. Attached to the empty IV antibiotic bag was an IV tubing with a label, change date: 1/31 discard date: 2/1. RN 5 verified he used the IV antibiotic tubing to hang the Fluconazole yesterday (February 2, 2019). RN 5 stated the IV antibiotic tubing should have been discarded on February 1, 2019, as indicated on the label. RN 5 further stated he should have not used the IV antibiotic tubing on February 2, 2019, and he should have use a new IV antibiotic tubing for Resident 89. On February 5, 2019, at 2:46 p.m., Resident 89's record review was conducted with Director of Nursing (DON) 2. Resident 89 was readmitted to the facility on [DATE], with diagnosis that included UTI. Resident 89's eMAR for February 2019, indicated the IV antibiotic Fluconazole 200 milligram was administered to Resident 89 on February 2, 2019, at 9 a.m. The facility's policy and procedure titled, Setting Up a Primary Infusion, dated July 26, 2010, was reviewed. The policy indicated, .IV - bags and tubing will be changed according to CDC (Center for Disease Control) infection control guidelines .Infusion Tubing .Intermittent q(every) 24 hr (hour) .Any tubing disconnected between infusions . 39503

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39503 Based on observation, interview, and record review, the facility failed to ensure, for four of seven residents (Residents 89, 94, 106, and 157) reviewed, received necessary respiratory care and services, when Residents 89, 94, and 106 were not monitored for the effective use of oxygen (O2). In addition, Residents 89, 94, 106, and 157 were not provided O2 humidifiers (device used to humidify supplemental O2) as ordered by the physician. These failures could result for the residents not to receive adequate O2 therapy as ordered by the physician to meet the residents' respiratory needs. Findings: 1. On February 3, 2019, at 9:32 a.m., a concurrent observation and interview was conducted with Registered Nurse (RN) 5. Resident 89 was lying in bed, on O2 at 3 liter per minute (lpm) via nasal cannula (nc - a tubing device used to deliver supplemental oxygen). The nasal cannula tubing was attached directly to the O2 concentrator (device used to deliver oxygen) without an O2 humidifier. RN 5 stated Resident 89 should have an O2 humidifier attached while on O2 use to prevent dryness on the nose. On February 6, 2019, at 11:14 a.m., Resident 89's record review was conducted with Licensed Vocational Nurse (LVN) 10. Resident 89 was readmitted to the facility on [DATE], with diagnoses that included pneumonia (lung infection). Resident 89's physician's order dated January 28, 2019, indicated: - Administer as needed O2 via nc to keep O2 saturation (sat - oxygen level in the blood) equal or above 92% (percent). May titrate (adjust) oxygen flow to 2-4 lpm; - Monitor oxygen saturation every shift with oxygen use; and - change humidifier and oxygen tubing weekly and as needed. Resident 89's physician order dated February 5, 2019, indicated the administration of O2 was changed from as needed to continuous. Resident 89's electronic Medication Administration Record (eMAR) for the month of January 2019, indicated the resident did not receive the O2 from January 28 to 31, 2019. There was no documented evidence of the O2 sat was monitored from January 28 to 31, 2019. Resident 89's eMAR for the month of February 2019, indicated the resident did not receive the O2 from February 1 to 5, 2019. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence O2 sat was monitored from February 1 to 6, 2019. There was no documented evidence Resident 89 received her O2 as ordered by the physician to be continuous on February 5, 2019. LVN 10 verified Resident 89 was on O2 at 3 lpm via nc. LVN 10 stated the O2 was considered a medication and it should have been documented as administered in the eMAR. LVN 10 stated Resident 89's O2 sat should have been documented if it was checked with the resident on O2 as ordered and how much O2 the resident was receiving or if the resident was on room air. LVN 10 stated accurate monitoring of Resident 89's O2 sat was needed to titrate the O2 as ordered and to evaluate for its effective used. 2. On February 3, 2019, at 8:50 a.m., Resident 94 was observed sitting in her wheelchair in the room, on O2 at 3 liter per minute (lpm) via nasal cannula (nc - a tubing device used to deliver supplemental oxygen). The nasal cannula tubing was attached directly to the O2 concentrator (device used to deliver oxygen) without an O2 humidifier. Resident 94 stated she used the O2 as needed in the morning and continuous at night when she slept. Resident 94 stated her nose was dry in the morning after using the O2 overnight. Subsequently, Licensed Vocational Nurse (LVN) 2 came into Resident 94's room. LVN 2 stated Resident 94 use her O2 as needed and confirmed the resident was on O2 at 3 lpm via nc without an O2 humidifier. LVN 2 stated O2 humidifier should be attached on the resident's O2 concentrator when the O2 was continuously used. LVN 2 stated the residents did not need O2 humidifier when they use the O2 as needed. On February 6, 2019, at 11:14 a.m., Resident 94's record review was conducted with LVN 10. Resident 94 was readmitted to the facility on [DATE], with diagnosis that included chronic obstructive pulmonary disease (COPD - lung disease that block the airflow and make it difficult to breathe). Resident 94's history and physical dated November 29, 2018, indicated the resident had the capacity to understand and make healthcare decisions. Resident 94's physician's order dated November 27, 2018, indicated: - Administer as needed O2 via nc to keep O2 saturation (sat - oxygen level in the blood) equal or above 92% (percent). May titrate (adjust) oxygen flow to 2-4 lpm; - Monitor oxygen saturation every shift with oxygen use; and - change humidifier and oxygen tubing weekly and as needed. There was no documented evidence Resident 94 received her O2 as needed from February 1 to 5, 2019. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 94's care plan dated December 27, 2017, indicated, .Focus: The resident has prn (as needed) oxygen therapy r/t (related to) copd . Goal: The resident will have no s/sx (sign and symptom) of poor oxygen absorption .The resident will have no complications related to SOB (shortness of breath) . Interventions .OXYGEN SETTINGS: O2 .prn . LVN 10 stated O2 was considered a medication and it should have been documented as administered in the eMAR when the resident needed it. LVN 10 stated Resident 94's O2 sat should have been documented if it was checked with the resident on O2 as ordered and how much O2 the resident was receiving or if the resident was on room air. LVN 10 stated accurate monitoring of Resident 94's O2 sat was needed to evaluate for the effective use of O2. 3. On February 3, 2019, at 10:15 a.m., a concurrent observation and interview was conducted with Registered Nurse (RN) 5. Resident 106 was lying in bed, on O2 at 3 liter per minute (lpm) via nasal cannula (nc - a tubing device used to deliver supplemental oxygen). The nasal cannula tubing was attached directly to the O2 concentrator (device used to deliver oxygen) without an O2 humidifier. RN 5 stated Resident 106 should have an O2 humidifier attached while on O2 use to prevent dryness on the nose. On February 6, 2019, at 11:14 a.m., Resident 106's record review was conducted with Licensed Vocational Nurse (LVN) 10. Resident 106 was readmitted to the facility on [DATE], with diagnosis that included bronchitis (inflammation of the lining of bronchial tubes, which carry air to and from the lungs). Resident 106's physician's order dated March 9, 2018, indicated administer O2 via nc to keep O2 saturation (sat - oxygen level in the blood) equal or above 92% (percent). May titrate (adjust) oxygen flow to 2-4 lpm. Monitor oxygen saturation every shift with oxygen use. There was no documented evidence Resident 106 receive her O2 as ordered by the physician to be continuous from January 2019 to February 2019. There was no documented evidence effective use of O2 was monitored from January 2019 to February 2019. Resident 106's care plan dated March 9, 2018, indicated, .Focus: The resident has oxygen therapy r/t (related to) shortness of breath . Goal: The resident will have no s/sx (sign and symptom) of poor oxygen absorption . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions .Give medications as ordered by physician. Monitor/document side effects and effectiveness . OXYGEN SETTING: O2 via 2-4 L (liter)/min (minute) via nasal cannula to keep O2 sat (saturation) > (more than) 92 % (percent) . LVN 10 verified Resident 106 was on O2 at 3 lpm via nc. LVN 3 stated O2 was a medication and it should have been documented as administered in the eMAR. LVN 10 stated Resident 106's O2 sat should have been documented if it was checked with the resident on O2 as ordered and how much O2 the resident was receiving or if the resident was on room air. LVN 10 stated accurate monitoring of Resident 106's O2 sat was needed to titrate the O2 as ordered and to evaluate for its effective used. 32191 4. On February 3, 2019, at 10:16 a.m., a concurrent interview and observation was conducted with the Licensed Vocational Nurse (LVN) 8. Resident 157 was observed lying in bed, Resident was on oxygen via nasal cannula (a tubing device used to deliver supplemental oxygen) at 3.5 liters per minute. Resident 157 did not have an oxygen humidifier attached on the nasal cannula tubing and concentrator (machine that deliver oxygen). LVN 8 confirmed and acknowledged Resident 157 did not have an oxygen humidifier in use while the resident was using the oxygen. On February 5, 2019, at 8:26 a.m., an observation and interview was conducted with Director of Nursing (DON) 2. Resident 157 was observed in bed with oxygen in used. Resident 157 stated he felt dryness inside his nose. DON 2 confirmed and acknowledged Resident 157 complained of dryness inside his nose. DON 2 stated Resident 157 should have been given an oxygen humidifier as ordered by the physician. On February 5, 2019, Resident 157's record was reviewed. Resident 157 was admitted to the facility on [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD- type of lung disease). Resident 157's physician's order dated January 9, 2019, indicated, .May have oxygen flow at 2-4 Liter per minute .Changed Humidifier and oxygen tubing every weekly and as needed every night shift . The facility's policy and procedure titled, Oxygen Administration, dated January 2018, was reviewed. The policy indicated, .The purpose of this procedure is to provide guidelines for safe oxygen administration .Turn on the oxygen as ordered .Check the mask, tank, humidifing jar, .to be sure they are in good working order and are securely fastened .

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39503 Based on observation, interview, and record review, the facility failed, for eight of 40 residents (Residents 77, 89, 4, 129, 277, 155, 172, and 154), to ensure pharmacy services were provided in a timely manner when: 1. For Resident 77, the new physician's order for Indomethacin (medication for pain), was not readily available to administer; 2. For Resident 89, the intravenous (IV - into the veins) antibiotic (Zosyn) to treat the resident's urinary tract infection (UTI) was not readily available to administer; 3. For Resident 4, the IV antibiotic (Vancomycin) to treat the resident's UTI was not readily available to administer; 4. For Resident 129, the routine medication - Norco (narcotic pain medication) was not readily available to administer for multiple scheduled doses; 5. For Resident 277, the routine medication - Fiorinal (a narcotic pain medication used for migraine - intense headache and sensitivity to light) was not readily available to administer for multiple scheduled doses; 6. For Resident 155, the new physician's order for Tramadol (narcotic pain medication) was not readily available to administer; 7. For Resident 172, the routine medication - Alprazolam (medication for anxiety) was not readily available to administer for multiple scheduled doses; and 8. For Resident 154, the routine medications - Neurontin (medication for neuropathy - pain from nerve damage) and Lipitor (medication for high cholesterol level) were not readily available to administer for multiple scheduled doses. These failures resulted in these residents not receiving medications as ordered by the physician to manage and treat medical conditions, and overall long-term health and well-being of the residents. On February 12, 2019 at 2:37 p.m., the facility's Administrator and Director of Nursing (DON) 1 were verbally notified of the system failure which resulted in Immediate Jeopardy (IJ). This system failure resulted in a delay in receiving necessary medications to managed pain, to treat infections and to treat other medical conditions of the residents. The IJ was removed on February 15, 2019 at 5:01 p.m., in the presence of the facility Administrator, after the facility's acceptable plan of action was reviewed and it was verified that the plan of action was implemented. Findings: (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. On February 3, 2019, at 11:49 a.m., Resident 77 was observed sitting in her wheelchair, with facial grimacing, was moaning and massaging her left hand. Resident 77 stated her left hand was hurting. Resident 77 showed her left hand, and the area around the left thumb was swollen. Resident 77 stated it had been swollen and hurting for a week now. Resident 77 further stated she was in a lot of pain last night, she cried and she was not able to sleep because of too much pain. Resident 77 stated her nurse did not give her anything for pain last night and told her she was waiting for the pharmacy to deliver the pain medication ordered by the physician. On February 5, 2019, at 11:06 a.m., a concurrent record review and interview was conducted with Licensed Vocational Nurse (LVN) 2. Resident 77 was admitted to the facility on [DATE], with diagnosis that included neuritis (inflammation of a peripheral nerve usually causing pain). Resident 77's physician's order dated February 2, 2019, at 9:22 a.m., indicated Indomethacin 50 milligram to give one capsule by mouth three times a day for inflammation (swelling). Resident 77's electronic Medication Record Administration (eMAR) for February 2019, indicated the medication Indomethacin was not administered on February 2, 2019, at 5 p.m., and indicated 9 (facility chart codes 9 = other/see progress notes) as the reason. Resident 77's progress notes dated February 2, 2019, at 7:31 p.m., indicated awaiting delivery for the medication Indomethacin. LVN 2 stated she called the physician on February 2, 2019, at 9 a.m. because Resident 77's left hand was still swollen and the resident still complained of pain. LVN 2 stated she received an order from the physician for Resident 77 to be started on Indomethacin. LVN 2 stated the physician's order was entered electronically in the resident's health record, and it would be transmitted directly to the pharmacy for medication delivery. LVN 2 stated the medication should have been delivered in the afternoon by the pharmacy since it was ordered on the morning of February 2, 2019. LVN 2 stated she did not call the pharmacy to inquire for the time of delivery of the medication Indomethacin. LVN 2 further stated the nurse from the evening shift should have called the pharmacy for follow up. On February 5, 2019, at 2:22 p.m., Director of Nursing (DON) 2 was interviewed. DON 2 stated the pharmacy delivery of medication was daily, three times a day. DON 2 stated, for new medication orders especially for pain, the nurse should have called the pharmacy to inquire for the time of delivery, to ensure the medication would be available for administration. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On February 11, 2019, at 8:45 a.m., the pharmacy owner (PO) was interviewed. The PO stated for new physician's order of medication, the pharmacy delivery would be within four hours after it was received in the pharmacy. The PO stated if the medication was available in the automated drug dispensing system (ADDS - computer controlled storage, dispensing and tracking of medications), the licensed nurse could use the medication from it while waiting for pharmacy delivery. The PO verified the physician's order for Indomethacin was received in the pharmacy on February 2, 2019, at 9:20 a.m., and it was delivered in the facility on February 3, 2019, at 3 a.m. The PO verified Indomethacin was not available in the ADDS. The PO stated the Indomethacin should have been delivered on February 2, 2019, at 12 noon. The PO further stated he did not know why it was not delivered as scheduled. 2. On February 5, 2019, at 2:46 p.m., Resident 89's record review was conducted with Director of Nursing (DON) 2. Resident 89 was readmitted to the facility on [DATE], with diagnosis that included UTI. Resident 89's physician's order dated January 28, 2019, at 8:29 p.m., indicated Zosyn 3.375 gram to be given IV every eight hours for UTI. Resident 89's electronic Medication Administration Record (eMAR) for the month of January 2019, indicated the IV antibiotic Zosyn did not have a signature to indicate it was administered to the resident on January 28, 2019, at 10 p.m. On February 11, 2019, at 8:45 a.m., the pharmacy owner (PO) was interviewed. The PO stated for new physician's order of medication, the pharmacy delivery would be within four hours after it was received in the pharmacy. The PO stated if the medication was available in the automated drug dispensing system (ADDS - computer controlled storage, dispensing and tracking of medications), the licensed nurse could use the medication from it while waiting for pharmacy delivery. The PO verified the IV antibiotic Zosyn was available from the ADDS. The PO verified Resident 89's physician's order of IV antibiotic Zosyn was received in the pharmacy on January 28, 2019, at 9:23 p.m., and 14 doses were delivered in the facility on January 29, 2019, at 5:23 a.m. The PO verified the IV antibiotic Zosyn for Resident 89 was not available for administration except from the stock in the ADDS. The PO stated there was no record the IV antibiotic Zosyn was pulled in the ADDS for Resident 89 on January 28, 2019. On February 7, 2019, at 4:22 p.m., Registered Nurse (RN) 1 was interviewed. RN 1 verified she was the RN assigned to give IV antibiotics on January 28, 2019, evening shift (3 p.m. to 11:30 p.m.) RN 1 verified Resident 89's eMAR for the month of January 2019, did not have her signature on IV antibiotic Zosyn to indicate it was administered to the resident on January 28, 2019, at 10 p.m. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RN 1 verified there was no documented evidence the IV antibiotic Zosyn was given to Resident 89 on January 28, 2019, at 10 p.m. as ordered. RN 1 stated she forgot to sign the eMAR but she administered the IV antibiotic Zosyn to Resident 89. RN 1 stated the IV antibiotic Zosyn she administered to the resident was from the discontinued medications stored in the medication room. RN 1 stated when an order of IV antibiotic for a resident was not available, the RNs in the facility would use, if it was available, discontinued IV antibiotic medications stored in the medication room. RN 1 stated she was aware when a medication was not available, the licensed nurse should call the pharmacy to inquire for the availability of the medication or the licensed nurse should get a dose from the ADDS when the medication was in stock and available for administration. RN 1 stated she did not call the pharmacy nor took a dose from the ADDS when Resident 89's IV antibiotic Zosyn was not available. RN 1 stated she used the IV Zosyn from discontinued medication and administered to Resident 89 on January 28, 2019, at 10 p.m. 3. On February 5, 2019, at 2:46 p.m., Resident 4's record review was conducted with Director of Nursing (DON) 2. Resident 4 was readmitted to the facility on [DATE], with diagnosis that included UTI. Resident 4's physician's order dated January 30, 2019, at 12:28 a.m., indicated Vancomycin 750 milligram (mg) to be given IV every eight hours for UTI. Resident 4's electronic Medication Administration Record (eMAR) for the month of January 2019, indicated the IV antibiotic Vancomycin 750 mg did not have a signature to indicate it was administered to the resident on January 30, 2019, at 6 a.m. Resident 4's (eMAR) for the month of February 2019, indicated the IV antibiotic Vancomycin did not have a signature to indicate it was administered to the resident on February 1, 2019, at 6 a.m. and 2 p.m. On February 11, 2019, at 8:45 a.m., the pharmacy owner (PO) was interviewed. The PO verified Resident 89's IV antibiotic Vancomycin 750 mg was delivered on January 29, 2019, for five doses and on February 2, 2019, for 10 doses. The PO stated there would be no IV antibiotic Vancomycin 750 mg available after the 5 doses were used by January 31, 2019, and before the 10 doses were delivered on February 2, 2019, unless it was pulled out from the automated drug dispensing system (ADDS - computer controlled storage, dispensing and tracking of medications). (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The PO verified there was no record the IV antibiotic Vancomycin was taken from the ADDS for Resident 4 on January 30 and 31, 2019 and February 1, 2019. On February 12, 2019, at 8:40 a.m., a concurrent record review and interview was conducted with RN 2. RN 2 verified he was the RN assigned to give IV antibiotics on January 30, 2019 and February 1, 2019, night shift (11 p.m. to 7:30 a.m.). RN 2 verified he did not sign Resident 4's eMAR on January 30, 2019, at 6 a.m., and February 1, 2019, at 6 a.m. to indicate the IV antibiotic Vancomycin was administered to the resident. RN 2 verified there was no documented evidence the IV antibiotic Vancomycin 750 mg was given on those dates as ordered. RN 2 verified Resident 4's eMAR for January 2019, indicated the IV antibiotic Vancomycin 750 mg were signed to indicate it was administered to Resident 4 on January 30, 2019, at 2 p.m. (as the first dose) through January 31, 2019, at 10 p.m. (as the last dose from the five doses delivered by the pharmacy on January 29, 2019). RN 2 stated he gave the IV antibiotic Vancomycin 750 mg to Resident 4 on January 30, 2019, at 6 a.m., and February 1, 2019, at 6 a.m. RN 2 further stated he forgot to sign the eMAR to indicate it was administered to the resident. RN 2 stated he could not remember where he got the IV antibiotic Vancomycin 750 mg on those dates. RN 2 stated he may have used the medication from the discontinued medications stored in the medication room or he may have borrowed from another resident that was on IV antibiotic Vancomycin. However, he was unable to provide documented evidence of either. On February 12, 2019, at 8:56 a.m., a concurrent record review and interview was conducted with RN 3. RN 3 verified she was the RN assigned to give IV antibiotics on February 1, 2019, day shift (7 a.m. to 3:30 p.m.). RN 3 verified she did not sign Resident 4's eMAR on February 1, 2019, at 2 p.m., to indicate the IV antibiotic Vancomycin 750 mg was administered to Resident 4. RN 3 verified there was no documented evidence the IV antibiotic Vancomycin 750 mg was given on February 1, 2019, at 2 p.m. as ordered. RN 3 stated if she did not sign the eMAR it meant the medication was not available. RN 3 stated she should have called the pharmacy or checked the ADDS for the availability of the IV antibiotic Vancomycin but she did not do it. 36684 4. On February 7, 2019, Resident 129's record was reviewed. Resident 129 was admitted to the facility on [DATE], with diagnoses that included chronic pain syndrome. The physician's order dated December 27, 2018, indicated to give Norco tablet 10-325 milligrams (mg) one tablet by mouth every six hours for pain management. (continued on next page)

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	555330	A. Building B. Wing	02/15/2019

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Riverside Postacute Care	8781 Lakeview Avenue Riverside, CA 92509

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The January 2019 electronic Medication Administration Record (eMAR), indicated the Norco medication was scheduled to be given at 12 a.m, 6 a.m., 12 p.m., and 6 a.m. In addition, the eMAR indicated Resident 129 did not receive the Norco tablet for pain on the following dates: - January 16, 2019, at 6 p.m.; - January 17, 2019, at 12 a.m.; and - January 21, 2019, at 12 a.m. and 6 a.m. The corresponding Medication Administration Notes for the dates Resident 129 did not receive her routine Norco medication for pain, indicated the licensed nurses were not able to give the medication because it was not available pending pharmacy delivery. On February 7, 2019, at 10:26 a.m., Licensed Vocational Nurse (LVN) 3 was interviewed. LVN 3 stated he was not able to administer the Norco medication to Resident 129 on January 21, 2019, at 12 a.m. and 6 a.m. , because the medication was not available. LVN 3 further stated there was a delay in the delivery of the medication from the pharmacy. LVN 3 stated the late delivery of medications had been an ongoing problem. LVN 3 stated he had called the pharmacy frequently to remind them of his refill orders request and to deliver the medication on time. LVN 3 stated the usual cause of the late delivery of the medication from the pharmacy was the pharmacy had to wait for a physician's authorization for a refill of the medication. On January 7, 2019, at 10:33 a.m., an observation with a concurrent interview was conducted on Resident 129. Resident 129 was alert and was up in her wheelchair inside her room. Resident 129 stated she took the routine Norco medication to help manage her chronic pain syndrome. Resident 129 stated she remembered missing a couple of doses of her Norco medication in January 2019. Resident 129 further stated the licensed nurses just kept telling her to wait at that time because it was going to be delivered soon. Resident 129 stated she waited but her Norco was not delivered on time. Resident 129 stated she felt her body tense up with pain when she did not get her Norco pain medication as scheduled. Resident 129 stated this was not the first time she had missed her medications because it was not available. Resident 129 stated, I really did not appreciate that. 5. On February 7, 2019, at 9:30 a.m., Resident 277's record was reviewed. Resident 277 was admitted to the facility on [DATE], with diagnoses that included migraine. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The physician's order dated November 8, 2018, indicated to give Fiorinal capsule 50-325-40 milligrams (mg) to be given by mouth three times a day for migraine. The January 2019 electronic Medication Administration Record (eMAR) indicated the medication Fiorinal was scheduled to be given at 6 a.m., 2 p.m., and 10 p.m. daily. In aadition, the eMAR indicated Resident 277 did not receive the medication Fiorinal on the following dates: - January 5, 2019 at 6 a.m., 2 p.m., and 10 p.m.; - January 6, 2019, at 6 a.m. and 10 p.m.; - January 7, 2019, at 6 a.m. and 10 p.m.; and - January 10, 2019, at 6 a.m., 2 p.m., and 10 p.m. The corresponding Medication Administration Notes for the dates Resident 277 did not receive her routine Fiorinal for migraine, indicated the licensed nurses were not able to give the medication because it was not available pending pharmacy delivery. On February 7, 2019, at 10:44 a.m., an observation with a concurrent interview was conducted on Resident 277. Resident 277 was in bed, alert, and conversant. Resident 277 stated the doctor prescribed the Fiorinal specifically to treat her bad migraine problem. Resident 277 stated she remembered missing doses of her medication in January 2019 because it was not available. She stated this was not the first time she had missed doses of her medications because of medication unavailability due to the delayed delivery from the pharmacy. Resident 277 stated the facility was aware of the issues with the late delivery of her medications because she had complained about it all the time. She stated she had been monitoring her medication supply because the licensed nurses let her medication run out before they called the pharmacy for a refill. On February 7, 2019, at 11:04 a.m., Licensed Vocational Nurse (LVN) 4 was interviewed. LVN 4 stated she was not able to administer Resident 277's Fiorinal on January 5, 2019 at 2 p.m. and January 10, 2019, at 2 p. m. LVN 4 further stated the Fiorinal was not administered because it was not available pending pharmacy delivery. LVN 4 stated there had been issues with the pharmacy regarding the delayed delivery of medications, which resulted in the residents not getting their medications on time as ordered by the physician. LVN 4 stated the pharmacy usually delivered a certain amount of medications good for at least three days only and the licensed nurses had to request for a refill order again. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LVN 4 stated she had asked the pharmacy why they only delivered a certain amount of medication that would only last a couple of days and she was told, That's all they had. On February 11, 2019, at 8:20 a.m., the Pharmacy Owner (PO) was interviewed. The PO stated he was not aware of the issues regarding the residents not receiving their medications on time due to medication unavailability as a result of delayed delivery of medications from the pharmacy. The PO further stated he was not informed the pharmacy had been having issues with the delay to get a physician's authorization to refill narcotic medications. The PO stated non-narcotic medication should have been delivered within four hours. The PO stated the licensed nurses should have requested refill orders for narcotic medications that needed physician auhtorization for refills, three to five days before they ran out of the medication. 32191 6. On February 3, 2019, at 9:45 a.m., Resident 155 was observed lying in bed, alert, and responsive. Resident 155 complained of back pain due to his broken bed. At 12:22 p.m., he was observed sitting in the wheel chair in the back dining room waiting for his lunch. Resident 155 complained of intolerable pain. Resident 155 requested to be put back to his bed. At 12:47 p.m., Resident was observed in the room sitting on the wheelchair. Resident stated he still had pain in his lower back since last night, due to his bed being broken. Resident 155 stated the nurse, told me I need to wait until tomorrow to fix my bed. When I turn it feels like the pain is stabbing me. On February 4, 2019, at 9:19 a.m., Resident 155 was observed lying in bed. Resident 155 had facial grimacing. and stated he had pain in his upper and lower back radiating to his hip. On February 4, 2019, at 9:47 a.m., an interview was conducted with the Licensed Vocational Nurse (LVN) 5. LVN 5 stated the Tramadol was ordered on February 3, 2019, at 2 p.m. LVN 5 stated the new order for Tramadol needed a physician's signature before the pharmacy could deliver the Tramadol. LVN 5 stated Tramadol was available in the automated drug dispensing system (ADDS - computer controlled storage, dispensing and tracking of medications), but required an access code to open the ADDS. LVN 5 further stated the pharmacist refused to give the access code until the physician's signature was obtained. On February 4, 2019, Resident 155's records were reviewed. Resident 155 was admitted to the facility on [DATE]. The History and Physical dated March 12, 2018, indicated, that Resident 155, can make needs known but can not make medical decisions. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 155's physician's order dated February 3, 2019, indicated, .Tramadol hydrochloride (HCL) tablet 50 milligram (MG) by mouth every six hours for pain management . Resident 155's electronic Medication Administration Record (eMAR) for the month of February 2019, indicated, the medication was not administered to Resident 155 on February 3, 2019, at 6 p.m. and February 4, 2019, at 12 a.m. On February 4, 2019, at 12:45 p.m., a follow up interview and record review was conducted with LVN 5. LVN 5 stated Resident 155 was scheduled to receive the Tramadol every six hours routinely for pain management, to start on February 3, 2019, at 6 p.m, but the medication was not available. LVN 5 further stated the Tramadol was not available because the pharmacy was waiting for the physician's signature prior to delivery of the medication On February 7, 2019, at 11:30 a.m., an interview was conducted with the Pharmacy Owner (PO). The PO stated he was not aware of the late delivery of the medication to the facility. PO stated until the physician signed the medication order, pharmacy would not give the code of the ADDS to the licensed nurse. The PO stated the access code for the ADDS will be given to the licensed nurse when the physician sign the new medication order. The PO stated the Pharmacist should have called the physician to follow up for the physician's signature. The PO further stated if there was no response from the physician, the pharmacist should have called the facility for assistance. On February 7, 2019, at 3 p.m., an interview was conducted with Director of Nursing (DON) 2. DON 2 stated Resident 155's pain medication should have been given in a timely manner as ordered by the physician. The undated facility's policy and procedure titled, MEDICATION ORDERING AND RECEIVING FROM PHARMACY, indicated, .New medications .If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery and request delivery within (4) hours .Timely delivery of new orders is required so that medication administration is not delayed . 7. On February 7, 2019, Resident 172's record was reviewed. Resident 172 was readmitted to the facility on [DATE], with a diagnoses that included anxiety (mental illness). Resident 172's physician order dated August 17, 2018, indicated, .Alprazolam tablet 0.5 milligram (mg) via gastrostomy tube (GT- incision in the abdominal wall used to administer medication and nutrition) every six hours for anxiety . The January 2019 electronic Medication Administration Record (eMAR), indicated the Alprazolam medication was scheduled to be given at 12 a.m, 6 a.m., 12 p.m., and 6 p.m. In addition the eMAR indicated Resident 172 did not receive the Alprazolam tablet for anxiety on the following dates: (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- January 11, 2019, at 6 p.m.; - January 12, 2019, at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - January 13, 2019, at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - January 14, 2019, at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - January 15, 2019, at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - January 16, 2019, at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - January 17, 2019, at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - January 18, 2019, at 12 a.m, and 6 a.m., - January 19, 2019, at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - January 20, 2019, at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - January 21, 2019, at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; and - January 22, 2019, at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; Resident 172's electronic Medication Administration Record (eMAR) for the month of January 11, 2019 to January 22, 2019, indicated the Alprazolam 0.5 mg was not given to the resident for 12 days, a total of 43 doses. On February 7, 2019, at 10:46 a.m., Director of Nursing (DON) 2 was interviewed. DON 2 confirmed and acknowledged Resident 172 missed 43 doses of Alprazolam. DIN 2 stated the Alprazolam was not available because the pharmacy was waiting for the physician's authorization. DON 2 stated the Licensed Nurses (LN) did not follow up with the pharmacy for the status of the refill order request of Alprazolam. DON 2 further stated the LN should have communicated with the pharmacy for the status of the request. DON 2 stated the LN should have notified the physician when the Alprazolam was not available. On February 7, 2019, at 11:30 a.m., an interview was conducted with the Pharmacy Owner (PO). The PO stated he was not aware of the late delivery of the medication to the facility. The PO stated non-narcotic medication should have been delivered within four hours. The PO stated the licensed nurses should have requested for refill orders, of narcotic medications that needed physician's authorization, three to five days before they ran out of the medication. 37537 (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8a. On February 5, 2019, Resident 154's record was reviewed. Resident 154 was admitted to the facility on [DATE], with diagnoses that included hyperlipidemia (high cholesterol in the blood) and neuropathy. Resident 154's electronic Medication Administration Record (eMAR) for the month of January 2019 was reviewed. The physician's orders in the eMAR indicated an order for Lipitor tablet 40 milligram (mg) to give one tablet orally at bedtime for hyperlipedemia. In addition the eMAR indicated the medication Lipitor was not administered to the resident on January 6, 8, 12, 13, 18, 19 and 23, 2019 at 8 p.m. The corresponding progress notes by the licensed nurses on those dates, indicated the medication was not administered to Resident 154 due to not being available per pharmacy. On February 11, 2019, at 8:21 a.m., the Pharmacy Owner (PO) was interviewed. The PO confirmed there was a request for the medication Lipitor refill received on January 6, 2019 and it was delivered on January 9, 2019, for 14 tablets. The PO stated the Lipitor should be available for administration after it was delivered on January 9, 2019. 8b. On February 5, 2019, Resident 154's electronic Medication Administration Record (eMAR) for the month of January 2019 was reviewed. The physician's orders in the eMAR indicated an order for Neurontin capsule, 300 milligram (mg) to give one capsule by mouth in the evening for neuropathy. In addition, the eMAR indicated the medication Neurontin was not administered to Resident 154 on January 18, 2019, at 5 p.m. The correspondending progress notes by the licensed nurse indicated the medication was not administered to Resident 154 due to not being available per pharmacy. On February 11, 2019, at 8:21 a.m., the Pharmacy Owner (PO) was interviewed. The PO confirmed there was a delivery of medication Neurointin on January 14, 2019, for 14 tablets. The PO stated Neurontin should be available for administration after it was delivered on January 14, 2019. On February 11, 2019, at 11:44 a.m., Director of Nursing (DON) 1 was interviewed. DON 1 stated licensed nurses should inform the charge nurse when medications were not available, they should call the pharmacy and notify the physician for missed medication doses. She further stated the residents were not getting their medications as ordered. The physician's orders are not being followed as it should. The undated facility policy titled , Medication Ordering and Receiving from Pharmacy was reviewed. The policy indicated, .Medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt . (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	if not automatically refilled by the pharmacy, repeat medications (refills) are .ordered as follows . Reorder medication (three to four) days in advance of need to assure an adequate supply is on hand. When reordering medication that requires special processing (such as Schedule II controlled substances .) .New medications, except for emergency or stat (need to give immediately) medications, are ordered as follows . If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and request delivery within (4) hours . Timely delivery of new orders is required so that medication administration is not delayed . The emergency kit is used when the resident needs a medication prior to pharmacy delivery .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39503 Based on interview and record review, the facility failed to ensure one of 10 residents reviewed (Resident 45) for unnecessary medication, the pharmacy consultant's (PC) recommendation was not reviewed and acted upon by the residents' physician. This failure resulted for the residents' medication used was not evaluated for possible identification of risk medication-related problems and complications the residents may have. Findings: 1. On February 12, 2019, at 4:05 p.m., a concurrent record review and interview was conducted with the Assistant Director of Nursing (ADON). Resident 45 was readmitted to the facility on [DATE], with diagnosis that included depression (type of behavioral disorder) and anxiety. Resident 45's physician's order dated July 3, 2018, indicated: - Klonopin (clonazepam - medication for anxiety) 0.5 milligram (mg) to give 1/2 (half) tablet by mouth two times a day; and - Pamelor (nortriptyline - medication use to treat depression) 10 mg to give one capsule by mouth at bedtime. Resident 45's, Consultant Pharmacist's Medication Regimen Review, dated December 25, 2018, indicated, . For Recommendation Created Between 12/1/2018 And 12/25/2018 . Resident is currently receiving the following antidepressant: Nortriptyline 10mg QHS (at bedtime) since 7/2018 for depression A review of the resident associated behaviors and monitoring parameters indicate no worsening of depression. Behaviors noted has been to be none to minimal . Please assess the patient and consider the following . decrease to Nortriptyline 10 mg every other night x5 days then dc (discontinue) . Consultant Pharmacist (name of the PC) . Resident 45's, Note To Attending Physician/Prescriber, dated January 31, 2019, indicated, .This resident is currently taking Klonopin 0.25mg BID (twice a day) ever since 7/2018 for anxiety . Please assess the patient and consider the following . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Decrease to Klonopin 0.25mg QD (once a day) . (name of the PC) . Resident 45's electronic Medication Administration Record (eMAR) for the month of February 2019, indicated: - Resident 45 was administered the medication Pamelor 10 mg 1 capsule by mouth at bedtime; and - Resident 45 was administered the medication Klonopin 0.5 mg 1/2 tablet by mouth two times a day. The ADON stated the PC would conduct a monthly Medication Regimen Review (MRR), then would submit the MRR report to the administrator, the Director of Nursing (DON), and the ADON. The ADON stated the resident's MRR report should be communicated to the resident's physician, to address any identified medication irregularities and medication recommendations made by the PC. The ADON stated there was no documented evidence Resident 45's physician reviewed the PC's identified medication irregularities and addressed the PC's recommendation on MRR report on December 25, 2018 and January 31, 2019. The undated facility's policy and procedure titled, Consultant Pharmacist Report, was reviewed. The policy indicated, .The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly .Recommendations are acted upon and documented by the facility staff and or the prescriber . Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36684 Based on interview, and record review, the facility failed, for two of 10 residents reviewed for unnecessary medications (Residents 43 and 83), to ensure monitoring for adverse consequences (such as signs and symptoms of bleeding) of anticoagulant medications (Xarelto {generic Rivaroxaban}- medications that reduce or prevent blood from clotting) when: 1. Resident 43 did not have documented evidence of monitoring for the adverse side effects of Rivaroxaban since ordered on July 24, 2018; and 2. Resident 83 did not have documented evidence of monitoring for the adverse effects of Xarelto since December 1, 2018. These failure had the potential to result in the residents to experience bleeding related to anticoagulant medication use. Findings: 1. On February 5, 2019, Resident 43's record was reviewed with Licensed Vocational Nurse (LVN) 7. Resident 43 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included Deep Vein Thrombosis (DVT - a blood clot in the deep vein usually the lower extremities) of left lower extremity. The physician's order dated July 24, 2018, indicated to give Rivaroxaban tablet 10 mg (milligrams) one tablet via G-tube (flexible tube surgically placed through the abdominal wall and into the stomach to provide nutrition) one time a day for DVT. The care plan dated July 24, 2018, indicated .The resident is on anticoagulant therapy Xarelto (brand name for Rivaroxaban) .Interventions .Monitor/document/report PRN (as needed) adverse reactions of ANTICOAGULANT therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), loss of appetite, sudden change in mental status, significant or sudden change in vital signs . In a concurrent interview, LVN 7 stated when a resident was placed on an anticoagulant medication such as Rivaroxaban, the resident should be monitored for adverse effects such as bleeding and bruising. LVN 7 further stated the monitoring for the adverse effect of the anticoagulant medication use needed a physician's order and the licensed nurses document their monitoring in the electronic Administration Record (eMAR) every shift. LVN 7 stated there was no documented evidence Resident 43 was monitored for the adverse effects of Rivaroxaban since it was ordered in July 24, 2018. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 7 stated Resident 43 did not have a physician's order to be monitored for the adverse effects of Rivaroxiban use. LVN 7 further stated Resident 43 should have been monitored. 32191 2. On February 5, 2019, Resident 83's record was reviewed with Director of Nurses (DON) 2 Resident 83 was admitted to the facility on [DATE], with diagnoses that included Deep Vein Thrombosis (DVT - a blood clot in the deep vein usually the lower extremities) of both lower extremity. The physician's order dated November 20, 2018, indicated to give Xarelto tablet 10 milligrams (MG) give 0.5 tablet by mouth one time a day for DVT. The care plan dated November 20, 2018, indicated .The resident is on anticoagulant therapy Xarelto related to DVT .Interventions .Monitor/document/report PRN (as needed) adverse reactions of ANTI_COAGULANT therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), loss of appetite, sudden change in mental status, significant or sudden change in vital signs . In a concurrent interview, DON 2 stated when a resident is placed on anticoagulants such as Xarelto, the resident should be monitored for adverse effects such as bleeding and bruising. DON 2 further stated the monitoring for the adverse effect of the anticoagulant medication use needed a physician's order and the licensed nurses document their monitoring in the electronic Administration Record (eMAR) every shift. DON 2 stated there was no documented evidence Resident 83 was monitored for the adverse effects of Xeralto since December 1, 2018. DON 2 stated Resident 83 did not have a physician's order to be monitored for the adverse effects of Xeralto use. DON 1 further stated Resident 83 should have been monitored for anticoagulant adverse effect . The facility's policy and procedure titled, Anticoagulant Therapy, dated April 2005, was reviewed. The policy indicated, .Throughout anticoagulant therapy monitor the residents for signs and symptoms of bleeding. If sign and symptoms of bleeding are noted, Hold anticoagulant medication and notify physician immediately .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37537 Based on interview and record review, the facility failed to ensure one of 10 residents (Resident 86) reviewed for unnecessary medication had the as needed (PRN) medication Trazadone (medication given for depression) orders limited to 14 days. This failure had the potential for the resident to develop an adverse reaction to the medication if given unnecessarily. Findings: On February 13, 2019, Resident 86's record was reviewed. Resident 86 was admitted to the facility on [DATE], with diagnoses that included depression (a type of behavioral disorder). Resident 86's physician's order dated January 26, 2019, indicated to administer Trazadone tablet 100 milligrams (MG), give 1 tablet by mouth every 24 hours as needed for depression for 90 days . Resident 86's, Consultant Pharmacist Medication Regimen Review, dated November 28, 2018, indicated . For Recommendation Created Between 11/24/2018 And 11/28/2018 . This resident is currently on a PRN Psychotropic: Trazadone PRN (8/1/18 - medication was started) . For pyschotropic drugs .that the attending physician believes a PRN prescription for longer than 14 days is appropriate, the attending physician can extend the prescription beyond 14 days for the resident by documenting their rationale . IF THERAPY IS TO EXCEED 14 DAYS, PLEASE SPECIFY A DURATION OF THERAPY . On February 13, 2019, at 8:30 a.m, a concurrent interview and record review was conducted with Director of Nursing (DON) 1. DON 1 verified Resident 86 was on Trazadone PRN for 90 days, since January 26, 2019. DON 1 further stated the order should be clarified with the physician or re-ordered the medication PRN Trazadone. DON 1 further stated it should be renewed every 14 days if used as PRN, per federal regulations. DON 1 stated there was no documented evidence the physician evaluated the resident for the continued use of the medication Trazadone for PRN dose. The facility's policy and procedure titled , ANTISYCHOTIC MEDICATIONS USE , dated January 2018, was reviewed. The policy indicated the attending physician will identify, evaluate and document with input from other disciplines and consultants as needed, symptoms that may warrant the use of antisychotic medications . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order .

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39503 Based on observation, interview, and record review, the facility failed to ensure eight of 40 residents reviewed (Residents 77, 89, 4, 129, 277, 155, 172, and 154) were free of significant medication error when: 1. Resident 77 did not receive her first dose of Indomethacin (medication for pain) as ordered by the physician. This failure resulted in the resident experiencing increased pain. 2. Resident 89, did not receive her intravenous (IV - into the veins) antibiotics (Zosyn and Fluconazole) on multiple occasions for treatment of a urinary tract infection (UTI). In addition, Resident 89 may have received discontinued IV antibiotic medication. This failure could jeopardize the resident's health and safety for not treating the UTI appropriately that could result into complications such as kidney damage. In addition, the resident could have received expired or inaccurate medication dosages from the possible use of discontinued medications. 3. Resident 4, did not receive his IV antibiotics (Merrem and Vancomycin) on multiple occasions for treatment of a UTI. In addition, Resident 4 may have received discontinued IV antibiotic medication. This failure could jeopardize the resident's health and safety for not treating the UTI appropriately that could result into complications such as kidney damage. In addition, the resident could have received expired or inaccurate medication dosages from the possible use of discontinued medications. 4. Resident 129 did not receive her routine medication Norco (narcotic pain medication) on multiple occasions for the month of [DATE]. This failure resulted in the resident to experience increased pain. 5. Resident 277 did not receive her routine medication Fiorinal (a narcotic pain medication used for migraine - intense headache and sensitivity to light) on multiple occasions for the month of [DATE]. This failure resulted in the potential for the resident to experience excessive migraine headaches. 6. Resident 155 did not receive three doses of the new physician's order of Tramadol (narcotic pain medication). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	This failure resulted in the resident to experiencing increased pain. 7. Resident 172 did not receive her routine medication Alprazolam (medication for anxiety) from [DATE] to 22, 2019. This failure put the resident at risk to experience increased anxiety. 8. Resident 172 did not receive her IV antibiotic Vancomycin on [DATE], at 9 a.m., for treatment of her pneumonia (lung infection). This failure could jeopardize the resident's health and safety for not treating the pneumonia that could result into complications such as respiratory failure and death. 9. Resident 154 did not receive his routine medication Albuterol (for treatment of chronic obstructive pulmonary disease {COPD - lung disease that block the airflow and make it difficult to breathe}) on multiple occasions at night when the resident was asleep from [DATE] to February 2019. This failure could jeopardize the resident's health and safety for not managing and treating the COPD that could result into complications such as respiratory failure and death. 10. Resident 154 did not receive his routine medications (Neurontin - medication for neuropathy {pain from nerve damage}; Lipitor - medication for high cholesterol level; Risperdal - treatment for schizophrenia {mental disorder}; and Protonix - medication for acid reflux) on multiple occasions for the month of [DATE]. This failure could jeopardize the resident's health and safety for not managing and treating the medical conditions, overall long-term health and well-being of the resident. On February 12, 2019 at 2:37 p.m., the facility's Administrator and Director of Nursing (DON) 1 were verbally notified of the system failure which resulted in an Immediate Jeopardy (IJ). This system failure resulted in a delay in receiving necessary medications to manage pain, to treat infections and to treat other medical conditions of the residents. The IJ was removed on February 15, 2019 at 5:01 p.m., in the presence of the facility Administrator, after the facility's acceptable plan of action was reviewed and it was verified that the plan of action was implemented. Findings: 1. On February 3, 2019, at 11:49 a.m., Resident 77 was observed sitting in her wheelchair, with facial grimacing, was moaning and massaging her left hand. Resident 77 stated her left hand was hurting. Resident 77 showed her left hand, and the area on the left thumb was swollen. Resident 77 stated it had been swollen and hurting for a week now. Resident 77 stated she was in a lot of pain last night, she cried and could not sleep because of too much pain. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She further stated her nurse did not give her anything for pain last night and told her she was waiting for the pharmacy to deliver the pain medication ordered by the physician. On February 5, 2019, at 11:06 a.m., a concurrent record review and interview was conducted with Licensed Vocational Nurse (LVN) 2. Resident 77 was admitted to the facility on [DATE], with diagnosis that included neuritis (inflammation of a peripheral nerve usually causing pain). Resident 77's physician's order dated February 2, 2019, at 9:22 a.m., indicated Indomethacin 50 milligram (mg) to give one capsule by mouth three times a day for five days for inflammation (swelling). A Physician's order dated [DATE], indicated Tylenol (pain medication) 650 mg to be given by mouth every six hours as needed for pain. Resident 77's electronic Medication Record Administration (eMAR) for February 2019, indicated the medication Indomethacin was not administered on February 2, 2019, at 5 p.m., and indicated 9 (facility chart codes 9 = other/see progress notes) as a reason. In addition, the eMAR did not indicate Resident 77 was offered non-pharmacological interventions nor was given the Tylenol for pain on February 2, 2019. Resident 77's progress notes dated February 2, 2019, at 7:31 p.m., indicated awaiting delivery for the medication Indomethacin. LVN 2 stated she called the physician on February 2, 2019, at 9 a.m. because Resident 77's left hand was still swollen and the resident still complained of pain. LVN 2 stated she received an order from the physician for Resident 77 to be started on Indomethacin. LVN 2 stated the physician's order was entered electronically, and it will be transmitted directly to the pharmacy for medication delivery. LVN 2 stated the medication should have been delivered in the afternoon by the pharmacy since it was ordered on the morning of February 2, 2019. LVN 2 stated she did not call the pharmacy to inquire for the time of delivery of the medication. LVN 2 further stated the nurse from the evening shift should have called the pharmacy to follow up. LVN 2 further stated Resident 77 was in pain on February 2, 2019. LVN 2 stated she should have offered non-pharmacological interventions or give the Tylenol to Resident 77 for pain management while waiting for the Indomethacin to be delivered. On February 5, 2019, at 2:22 p.m., Director of Nursing (DON) 2 was interviewed. DON 2 stated the pharmacy delivery of medications in the facility were daily, three times a day. DON 2 stated, for new medication orders especially for pain, the nurse should have called the pharmacy to inquire for the time of delivery, to ensure the medication would be available for administration. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	DON 2 stated Resident 77 should have offered non-pharmacological interventions or given the Tylenol for pain while waiting for the Indomethacin to be delivered. The undated facility policy and procedure titled, MEDICATION ORDERING AND RECEIVING FROM PHARMACY, indicated, .New medications .If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery and request delivery within (4) hours .Timely delivery of new orders is required so that medication administration is not delayed . 2. On February 5, 2019, at 2:46 p.m., Resident 89's record review was conducted with Director of Nursing (DON) 1. Resident 89 was readmitted to the facility on [DATE], with diagnosis that included UTI. Resident 89's physician's order indicated the following: - on [DATE], Zosyn 3.375 gram to be given IV every eight hours for UTI. - on [DATE], Fluconazole 200 milligram (mg) to be given IV once a day for UTI. Resident 89's electronic Medication Administration Record (eMAR) for the month of [DATE], indicated the IV antibiotic Zosyn did not have a signature indicating it was administered to the resident on [DATE] at 10 p.m. and [DATE], at 6 a.m. Resident 89's eMAR for the month of February 2019, indicated the following, for IV antibiotics: - Zosyn did not have a signature to indicate it was administered to the resident on February 1, 2019 at 6 a.m. and 2 p.m.; - Fluconazole did not have a signature to indicate it was administered to the resident on February 1, 2019 at 9 a.m. On February 7, 2019, at 4:22 p.m., Registered Nurse (RN) 1 was interviewed. RN 1 verified she was the RN assigned to give IV antibiotics on [DATE], evening shift (3 p.m. to 11:30 p.m.) RN 1 verified Resident 89's eMAR for the month of [DATE] did not have her signature on the IV antibiotic Zosyn to indicate it was administered to the resident on [DATE], at 10 p.m. RN 1 verified there was no documented evidence the IV antibiotic Zosyn was given to Resident 89 on [DATE], at 10 p.m. as ordered. RN 1 stated she forgot to sign the eMAR but she administered the IV antibiotic Zosyn to Resident 89. RN 1 stated Resident 89's IV antibiotic Zosyn was not available due to pharmacy delivery. RN 1 further stated the IV Zosyn she administered to Resident 89 was from the discontinued medications stored in the medication room. However, she was unable to provide documented evidence. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RN 1 stated when an order of IV antibiotic for a resident was not available, the RNs in the facility would use, if it was available, discontiued IV antibiotic medications stored in the medication room. RN 1 stated she was aware when a medication was not available, the licensed nurse should call the pharmacy to inquire for the availability of the medication or the licensed nurse should get a dose from the automated drug dispensing system (ADDS - computer controlled storage, dispensing and tracking of medications) when the medicacation was in stock and available for administration. RN 1 stated she did not call the pharmacy nor took a dose from the ADDS when Resident 89's IV antibiotic Zosyn was not available. RN 1 stated she used the IV Zosyn antibiotic from discontinued medication to administer to Resident 89 on [DATE], at 10 p.m. On February 12, 2019, at 8:40 a.m., RN 2 was interviewed. RN 2 verified he was the RN assigned to give IV antibiotics on [DATE] and February 1, 2019 at night shift (11 p.m. to 7:30 a.m.) RN 2 verified Resident 89's eMAR did not have his signature on the IV antibiotic Zosyn to indicate it was administered to the resident on [DATE], at 6 a.m. and February 1, 2019, at 6 a.m. RN 2 verified there was no documented evidence the IV antibiotic Zosyn was given to Resident 89 on [DATE], at 6 a.m. and February 1, 2019, at 6 a.m. as ordered. RN 2 verified he made a late entry on February 5, 2019, by signing the eMAR for [DATE], at 6 a.m. and February 1, 2019, at 6 a.m. for the IV antibiotic he did not sign. RN 2 stated he should have signed the eMAR after each administration of the medication to the resident. RN 2 further stated he could not remember if the antibiotics were given or not to Resident 89 on the dates he did not sign. RN 2 stated he was told by the facility that he missed signing the eMAR so he made a late entry. RN 2 further stated he was not sure, for the late entry signature he made, if the antibiotic Zosyn was administered to Resident 89 or not. On February 12, 2019, at 8:56 a.m., RN 3 was interviewed. RN 3 verified she was the RN assigned to give IV antibiotics on February 1, 2019, day shift (7 a.m. to 3:30 p.m.) RN 3 verified Resident 89's eMAR for the month of February 2019, had the following IV antibiotic order: - Zosyn did not have her signature to indicate it was administered to the resident on February 1, 2019, at 2 p. m.; and - Fluconazole did not have her signature to indicate it was administered to the resident on February 1, 2019, at 9 a.m. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RN 3 verified there was no documented evidence the IV antibiotic Zosyn and Fluconazole were administered to Resident 89 on February 1, 2019, at 9 a.m. and 2 p.m. as ordered. RN 3 verified she made a late entry on February 6, 2019, by signing the eMAR on February 1, 2019, at 9 a. m. and 2 p.m. for the IV antibiotics she did not sign. RN 3 stated she should have signed the eMAR after each administration of the medication to the resident. RN 3 further stated she could not remember if the antibiotics were given or not to Resident 89 on the dates she did not sign. RN 3 stated she received her eMAR audits from the medical records with the missing signature. RN 3 further stated she just wanted to fix her audits and made sure there was nothing missing on Resident 89's eMAR. 3. On February 5, 2019, at 2:46 p.m., Resident 4's record review was conducted with Director of Nursing (DON) 2. Resident 4 was readmitted to the facility on [DATE], with diagnosis that included UTI. Resident 4's physician's order indicated the following: - on [DATE], Meropenem (Merrem) one gram to be given IV every eight hours for UTI. - on [DATE], Vancomycin 750 milligram (mg) to be given IV every eight hours for UTI. Resident 4's electronic Medication Administration Record (eMAR) for the month of [DATE], indicated the IV antibiotics Vancomycin and Merrem did not have a signature indicating it was administered to the resident on [DATE], at 6 a.m. Resident 4's eMAR for the month of February 2019, indicated the IV antibiotics Vancomycin and Merrem did not have a signature indicating it was administered to the resident on February 1, 2019, at 6 a.m. and 2 p.m. On February 12, 2019, at 8:40 a.m., a concurrent record review and interview was conducted with RN 2. RN 2 verified he was the RN assigned to give IV antibiotics on [DATE] and February 1, 2019, night shift (11 p.m. to 7:30 a.m.). RN 2 verified he did not sign Resident 4's eMAR on [DATE], at 6 a.m., and February 1, 2019, at 6 a.m. to indicate the IV antibiotics Vancomycin and Merrem were administered to the resident. RN 2 verified there was no documented evidence the IV antibiotics Vancomycin and Merrem were given on those dates as ordered. RN 2 verified he made a late entry on February 5, 2019, by signing the eMAR on [DATE], at 6 a.m. and February 1, 2019, at 6 a.m., for the IV antibiotics he did not sign RN 2 stated he should have signed the eMAR after each administration of the medication to the resident. RN 2 further stated he could not remember if the antibiotics were given or not to Resident 4 on the dates he did not sign. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RN 2 stated he was told by the facility that he missed signing the eMAR so he made a late entry. RN 2 further stated he was not sure for the late entry signature he made if the IV antibiotics were administered to Resident 4 or not. RN 2 stated for Resident 4's IV antibiotic Vancomycin, he may have used the medication from the discontinued medication or he may have borrowed from another resident that was on IV antibiotic Vancomycin. However, he was unable to provide documented evidence of either. On February 12, 2019, at 8:56 a.m., a concurrent record review and interview was conducted with RN 3. RN 3 verified she was the RN assigned to give IV antibiotics on February 1, 2019, day shift (7 a.m. to 3:30 p.m.). RN 3 verified she did not sign Resident 4's eMAR on February 1, 2019, at 2 p.m., to indicate the IV antibiotic Vancomycin and Merrem were administered to the resident. RN 3 verified there was no documented evidence the IV antibiotic Vancomycin and Merrem were given on February 1, 2019, at 2 p.m. as ordered. RN 3 verified she made a late entry on February 6, 2019, by signing the eMAR for February 1, 2019 at and 2 p.m. for the IV antibiotics she did not sign. RN 3 stated if she did not sign the eMAR it meant the medication was not available or she did not administer it. RN 3 further stated she could not remember if the antibiotics were given or not to Resident 4 on the dates she did not sign. RN 3 stated she received her eMAR audits from the medical records with the missing signature. RN 3 further stated she just wanted to fix her audits and made sure there was nothing missing on Resident 4's eMAR. The facility policy and procedure titled, Administering Medications, dated [DATE], was reviewed. The policy indicated, .Medications shall be administered in a safe and timely manner, and as prescribed .The individual administering the medication must initial the resident's MAR after giving each medication and before administering the next ones .Medications ordered for a particular resident may not be administered to another resident . The undated facility's policy and procedure titled, DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES, was reviewed. The policy indicated, .When medications are discontinued by a prescriber .the medications are marked as discontinued and destroyed .Medications are removed from the medication cart immediately upon receipt of an order to discontinue (to avoid inadvertent administration) . 36684 4. On February 7, 2019, Resident 129's record was reviewed. Resident 129 was admitted to the facility on [DATE], with diagnoses that included chronic pain syndrome. The physician's order dated [DATE], indicated to give Norco tablet ,d+[DATE] milligrams (mg) one tablet by mouth every six hours for pain management. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The [DATE] electronic Medication Administration Record (eMAR), indicated the Norco medication was scheduled to be given at 12 a.m, 6 a.m., 12 p.m., and 6 a.m. In addition, the eMAR indicated Resident 129 did not receive the Norco tablet for pain on the following dates: - [DATE], at 6 p.m.; - [DATE], at 12 a.m.; and - [DATE], at 12 a.m. and 6 a.m. The corresponding Medication Administratuion Notes for the dates Resident 129 did not receive her routine Norco medication for pain, indicated the licensed nurses were not able to give the medication because it was not available pending pharmacy delivery. On February 7, 2019, at 10:26 a.m., Licensed Vocational Nurse (LVN) 3 was interviewed. LVN 3 stated he was not able to administer the Norco medication to Resident 129 on [DATE], at 12 a.m. and 6 a.m., because the medication was not available. LVN 3 further stated there was a delay in the delivery of the medication from the pharmacy. On [DATE], at 10:33 a.m., an observation with a concurrent interview was conducted on Resident 129. Resident 129 was alert and was up in her wheelchair inside her room. Resident 129 stated she took the routine Norco medication to help manage her chronic pain syndrome. Resident 129 stated she remembered missing a couple of doses of her Norco medication in [DATE]. Resident 129 further stated the licensed nurses just kept telling her to wait at that time because it was going to be delivered soon. Resident 129 stated she waited but her Norco was not delivered on time and she missed some doses scheduled. Resident 129 stated she felt her body tense up with pain when she did not get her Norco pain medication as scheduled. Resident 129 stated this was not the first time she had missed her medications because it was not available. Resident 129 stated, I really did not appreciate that. 5. On February 7, 2019, at 9:30 a.m., Resident 277's record was reviewed. Resident 277 was admitted to the facility on [DATE], with diagnoses that included migraine. The physician's order dated [DATE], indicated to give Fiorinal capsule (a narcotic pain medication used to treat tension headaches) [DATE] milligrams (mg) to be given by mouth three times a day for migraine. The [DATE] electronic Medication Administration Record (eMAR) indicated the medication Fiorinal was scheduled to be given at 6 a.m., 2 p.m., and 10 p.m. daily. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In addition, the eMAR indicated Resident 277 did not receive the medication Fiorinal on the following dates: - [DATE] at 6 a.m., 2 p.m., and 10 p.m.; - [DATE], at 6 a.m. and 10 p.m.; - [DATE], at 6 a.m. and 10 p.m.; and - [DATE], at 6 a.m., 2 p.m., and 10 p.m. The corresponding Medication Administration Notes for these dates that Resident 277 did not receive her routine Fiorinal medication for migraine, indicated the licensed nurses were not able to give the medication because it was not available pending pharmacy delivery. On February 7, 2019, at 10:44 a.m., an observation with a concurrent interview was conducted on Resident 277. Resident 277 was in bed, alert, and conversant. Resident 277 stated the doctor prescribed her the Fiorinal medication specifically to treat her bad migraine problem. Resident 277 stated she remembered missing doses of her Fiorinal medication in [DATE] because the medication was not available. Resident 277 stated this was not the first she had missed doses of her medication because of medication unavailability due to the delayed delivery of her medication from the pharmacy. Resident 277 stated she had been monitoring her medication supply because the licensed nurses let her medication run out before they call the pharmacy for a refill. Resident 277 stated the Fiorinal was the only medication that helped her treat her bad migraine problem. On February 7, 2019, at 11:04 a.m., Licensed Vocational Nurse (LVN) 4 was interviewed. LVN 4 stated she was not able to administer Resident 277's Fiorinal medication on [DATE] at 2 p.m. and [DATE], at 2 p.m. LVN 4 further stated the Fiorinal medication was not administered because it was not available pending pharmacy delivery. LVN 4 stated there had been issues with the pharmacy regarding the delayed delivery of medications, which resulted in the residents not getting their medications on time as ordered by the physician. The facility's policy and procedure titled, Administering Medications, dated [DATE], was reviewed. The policy indicated, .Medications shall be administered in a safe and timely manner, and as prescribed . 32191 6. On February 3, 2019, at 9:45 a.m., Resident 155 was observed lying in bed, alert, and responsive. Resident 155 complained of back pain due to his broken bed. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	At 12:22 p.m., Resident 155 was observed sitting in the wheel chair in the back dining room waiting for his lunch. Resident complained of intolerable pain, and requested to be put back to bed. At 12:47 p.m., Resident 155 was observed in the room sitting on the wheelchair. Resident 155 stated he was still having pain in his lower back since last night, due to his bed being broken. Resident 155 stated, the nurse told me I need to wait until tomorrow to fix my bed. When I turn it feels like the pain is stabbing me. On February 4, 2019, at 9:19 a.m., Resident 155 was observed lying in bed. Resident 155 had facial grimacing and stated he had pain in his upper and lower back radiating to his hip. On February 4, 2019, at 9:47 a.m., an interview was conducted with the Licensed Vocational Nurse (LVN) 5. LVN 5 stated Tramadol was ordered on February 3, 2019, at 2 pm. LVN 5 stated the new order for Tramadol needed a physician's signature before the pharmacy could deliver it. LVN 5 stated the Tramadol was available in the automated drug dispensing system (ADDS - computer controlled storage, dispensing and tracking of medications), but required an access code to open the ADDS. LVN 5 stated the pharmacist refused to give the access code until the physician's signature was obtained. On February 4, 2019, Resident 155's record was reviewed. Resident 155 was admitted to the facility on [DATE]. The History and Physical dated [DATE], indicated that Resident 155, can make needs known but can not make medical decisions. Resident 155's physician's order dated February 3, 2019, indicated, .Tramadol hydrochloride (HCL) tablet 50 milligram (MG) by mouth every six hours for pain management . Resident 155's electronic Medication Administration Record (eMAR) for the month of February 2019, indicated the medication was not administered to Resident 155 on February 3, 2019, at 6 p.m. and February 4, 2019, at 12 a.m. On February 4, 2019, at 12:45 p.m., a follow up interview and record review was conducted with LVN 5. LVN 5 stated Resident 155 was scheduled to received the Tramadol every six hours routinely for pain management, to start on February 3, 2019, at 6 p.m, but the medication was not available. LVN 5 further stated the Tramadol was not available because the pharmacy was waiting for the physiciana's signature prior to delivery of the medication On February 7, 2019, at 11:30 a.m., an interview was conducted with the Pharmacy Owner (PO). The PO stated he was not aware of the late delivery of the medication to the facility. The PO stated until the physician signed the medication order, the pharmacy would not give the ADDS code to the licensed nurse. The PO stated the access code for the ADDS will be given to the licensed nurse when the physician sign the new medication order. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The PO stated the Pharmacist should have called the physician to follow up on the physician's signature. The PO further stated if there was no response from the physician, the pharmacist should have called the facility for assistance. On February 7, 2019, at 3 p.m., an interview was conducted with Director of Nursing (DON) 2. DON 2 stated Resident 155's pain medication should have been given in a timely manner as ordered by the physician. The undated facility's policy and procedure titled, MEDICATION ORDERING AND RECEIVING FROM PHARMACY, indicated, .New medications .If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery and request delivery within (4) hours .Timely delivery of new orders is required so that medication administration is not delayed . 7. On February 7, 2019, Resident 172's record was reviewed. Resident 172 was readmitted to the facility on [DATE], with a diagnoses that included anxiety (mental illness). Resident 172's physician order dated [DATE], indicated, .AlpraZolam tablet 0.5 milligram (mg) via gastrostomy tube (GT- incision in the abdominal wall used to administer medication and nutrition) every six hours for anxiety . The [DATE] electronic Medication Administration Record (eMAR), indicated the Alprazolam medication was scheduled to be given at 12 a.m, 6 a.m., 12 p.m., and 6 p.m. In addition the eMAR indicated Resident 172 did not receive the Alprazolam on the following dates: - [DATE], at 6 p.m.; - [DATE], at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - [DATE], at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - [DATE], at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - [DATE], at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - [DATE], at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - [DATE], at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - [DATE], at 12 a.m, and 6 a.m., - [DATE], at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - [DATE], at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; - [DATE], at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; and (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- [DATE], at 12 a.m, 6 a.m., 12 p.m., and 6 p.m; Resident 172's eMAR for the month of [DATE] to [DATE], the Alprazolam 0.5 mg was not given to the resident for 12 days, a total of 43 doses. On February 7, 2019, at 10:46 a.m., Director of Nursing (DON) 2 was interviewed. DON 2 confirmed and acknowledged Resident 172 missed 43 doses of Alprazolam 0.5 mg. DON 2 stated the Alprazolam was not available because the pharmacy was waiting for the physician's authorization. DON 2 stated the Licensed Nurses (LN) did not follow up with the pharmacy for the status of Alprazolam refill. DON 2 further stated the LN should have communicated with the pharmacy for the status of the request. DON 2 stated the LN should have notified the physician when Resident 172's Alprazolam was not available. On February 7, 2019, at 11:30 a.m., an interview was conducted with the pharmacy Owner (PO). The PO stated he was not aware of the medications late delivery of the medication to the facility. The PO stated the LN should have requested refill orders, for medications that needed physician auhtorization, three to five days before they ran out of the medication. 8. On February 7, 2019, Resident 172's record was reviewed. Resident 172 was readmitted to the facility on [DATE]. Resident 172's History and Physical dated [DATE], indicated, does not have the capacity to understand and make decisions. Resident 172's physician's order dated [DATE], indicated, .Vancomycin HydroChloride Solution (HCL) 750 milligram (mg) intravenously every twelve hours until [DATE], for pneumonia . The [DATE] electronic Medication Administration Record (eMAR) indicated Resident 172 did not receive the Vancomycin medication on [DATE], at 9 a.m. The corresponding nurses notes on the dates the medication was not administered to Resident 172 indicated, the IV Vancomycin was not administered to the resident due to pending delivery from the pharmacy. There was no documented evidence Resident 172's physician was notified the IV Vancomycin was not administered to the resident. On February 7, 2019, at 8:50 a.m., an interview was conducted with the Registered Nurse (RN) 3. RN 3 stated she did not administer the IV Vancomycin because it was not available. RN 3 further stated the pharmacy was unreliable. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On February 7, 2019, at 11:30 a.m., an interview was conducted with Pharmacy Owner (PO). The PO stated the Vancomycin was delivered and signed received by the RN 2 on [DATE], at 5 a.m. On February 7, 2019, at 11:50 a.m., a follow up interview was conducted with the RN 3. RN 3 stated she did not see the IV Vancomycin inside the IV Medication Cart. RN 3 confirmed she did not administer the IV medication on [DATE], at 9 a.m. 37537 9. On February 5, 2019, Resident 154's record was reviewed. Resident 154 was admitted to the facility on [DATE], with diagnoses that included COPD. Resident 154's electronic Medication Administration Record (eMAR) for the month of [DATE], [DATE], and February 2019 were reviewed. The physician's orders in the eMAR indicated Albuterol 2.5 milligrams (mg) / 3 milliliters (ml) 0.083% (percent) inhale orally via nebulizer (drug delivery device used to administer medication in the form of a mist) every four hours for shortness of breath (SOB) to be given at 12 a.m., 4 a.m. , 8 a.m., 12 p.m., 6 p.m., and 12 a.m., daily. Further review of the eMAR indicated Resident 154 did not rec [TRUNCATED]

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37537 Based on observation, interview, and record review, the facility failed to ensure sanitary conditions were maintained when the residents' refrigerator in the nursing station 1, had an opened food items readily available for consumption, were stored for more than 2 days. This failure could increase the potential for food borne illness for the residents. Findings: On February 5, 2019, at 10:24 a.m., an inspection of the residents' refrigerator inside nurse station 1 was conducted with Licensed Vocational Nurse (LVN 11) . The following residents' food items were observed: - A food item wrapped in foil, dated February 1, 2019; - One package of salami with an open date [DATE]; - A plastic bag containing outside food was dated February 2, 2019 ; - A sandwich and a food item wrapped in foil inside a zip lock bag dated February 2, 2019; - Food stored in a Styrofoam bowl dated February 2, 2019. In a concurrent interview, LVN 11 stated the resident's food items should only be kept for 72 hours. On February 5, 2019, at 10:35 a.m., an interview was conducted with the Director of Nursing (DON 2). DON 2 stated the residents refrigerator in nursing station 1 is checked every day for expired food items. The undated facility's policy and procedure titled, FOOD FOR RESIDENTS FROM OUTSIDE SOURCES , was reviewed. The policy indicated . If opened, the food must be sealed, dated to the date opened and disposed of in 2 days after opening .

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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** 36684 Based on interview and record review for one of 40 residents reviewed (Residents 326) the facility failed to ensure an accurate medical record was maintained when the face sheet indicated resident was self-responsible (had the capacity to understand and make medical decisions for himself), but the History and Physical (H&P) form indicated resident was able to make needs known but cannot make medical decisions. This failure had the potential for the resident to not receive the appropriate care/treatment and services due to inaccurate information in his medical records. Findings: On February 11, 2019. at 9:13 a.m., Resident 326's record was reviewed with the Social Service Director (SSD). Resident 326 was admitted to the facility on [DATE]. Resident 326's face sheet indicated he was self-responsible. The H&P completed by the Physican Assistant (PA), dated January 21, 2019, indicated Resident 326 can make needs known but cannot make medical decisions. In a concurrent interview, the SSD stated the PA must have made an error in the H&P because Resident 326 was very alert, oriented and he had been making self-decisions since he was admitted to the facility. The SSD stated the H&P in Resident 326's record was inaccurate. On February 11, 2019, at 9:33 a.m., Resident 326 was interviewed with the SSD. Resident 326 was asked if he was aware the PA had indicated he was not able to make medical decisions when he was last seen by the PA on January 21, 2019. Resident 326 became upset and stated he was not aware the PA indicated that in his H&P. Resident 326 stated he was very much alert and was capable of making his own medical decisions. On February 13, 2019, at 9:45 a.m., Resident 236's record was reviewed with the SSD. The SSD stated the PA was in the facility February 12, 2019, and she had corrected Resident 236's H&P dated January 21, 2019. The PA had crossed out the section indicating the resident can make needs known but can not make medical decisions, and marked the section indicating the resident had the capacity to understand and make medical decisions. The date on the H&P corrected by the PA on February 12, 2019 was not changed. In a concurrent interview, the SSD stated the PA should have done a re-assessment on the resident to determine his decison making capacity. The SSD stated the PA should have completed a new H&P form and dated it February 12, 2019, when she did her re-assessment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 13, 2019, at 1:50 p.m., Resident 326's physician was interviewed. Resident 226's physician stated the H&P for Resident 326, completed by his PA on January 21, 2019, was an error. The physician stated a re- assessment on Resident 326's decision making capacity should have been conducted by the PA. The PP 1 stated he would address the issue promptly. The facility's policy and procedure titled, Record Content, dated January 2014, was reviewed. The policy indicated, .Resident's health record shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each resident .

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F 0867 Level of Harm - Actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 39503 Based on interview, and record review, the facility's Quality Assessment and Assurance (QAA) committee failed to identify, develop, and implement an appropriate plan of action to correct quality deficiencies related to Pharmaceutical Services when: 1. The facility failed to identify quality concerns regarding the residents' medication availability for administration (Cross Reference F755); and 2. The facility failed to identify quality concerns regarding licensed nurses care practices that meets expected professional standards, when multiple licensed nurses failed to follow the facility's policy and procedure for medication administration (Cross Reference F684 and F760). These failures placed the residents at risk for delay in receiving necessary medications to manage pain, to treat infections and to treat other medical conditions. The above failures had resulted in an Immediate Jeopardy and Substandard Quality of Care. Findings: On February 7, 2018, the following records were reviewed: - Resident 77's electronic Medication Administration Record (eMAR) indicated the resident did not receive her first dose of Indomethacin (medication for pain); - Resident 89's eMAR for the month of January 2019 and February 2019, indicated the resident did not receive her intravenous (IV - into the veins) antibiotics (Zosyn and Fluconazole) on multiple occasions for treatment of a urinary tract infection (UTI); - Resident 4's eMAR for the month of January 2019 and February 2019, indicated the resident did not receive his IV antibiotics (Merrem and Vancomycin) on multiple occasions for treatment of a UTI; - Resident 129's eMAR for the month of January 2019, indicated the resident did not receive her routine medication Norco (narcotic pain medication) on multiple occasions; - Resident 277's eMAR for the month of January 2019, indicated the resident did not receive her routine medication Fiorinal (a narcotic pain medication used for migraine - intense headache and sensitivity to light) on multiple occasions; - Resident 155's eMAR for the month of February 2019, indicated the resident did not receive three doses of a new physician's order of Tramadol (narcotic pain medication); - Resident 172's eMAR for the month of January 2019, indicated the resident did not receive her routine medication Alprazolam (medication for anxiety) from January 11 to 22, 2019 (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Some	In addition, Resident 172 did not receive her intravenous (IV) antibiotics (Vancomycin) for treatment of pneumonia (lung infection); and - Resident 154's eMAR indicated the resident did not receive his routine medication Albuterol (for treatment of chronic obstructive pulmonary disease {COPD - lung disease that block the airflow and make it difficult to breathe}) on multiple occasions at night when the resident was asleep from December 2018 to February 2019. In addition, Resident 154 did not receive his routine medications (Neurontin - medication for neuropathy {pain from nerve damage}; Lipitor - treatment for high cholesterol level; Risperdal - treatment for schizophrenia {mental disorder}; and Protonix - treatment of acid reflux) on multiple occasions for the month of January 2019. On February 7, 2019, at 10:29 a.m., the Administrator was interviewed. The Administrator stated one of the QAA projects for improvement was the medication administration review. The Administrator further stated it was the Assistant Director of Nursing (ADON) who was assigned to do it. The Administrator stated he was not familiar on the details of the medication administration review because he had no clinical background. The Administrator further stated he relied on the reports being given to him from the nursing staff team. The Administrator stated the report he received from the ADON had no issues or concerns on residents' medication being available for administration. The Administrator stated there were some concerns on the delay with the pharmacy obtaining authorization from the physician and it was addressed on the QAA meeting with the pharmacy consultant last December 2018. On February 7, 2019, at 11:03 a.m., the Pharmacy Consultant (PC) was interviewed. The PC stated she was made aware of the issue for delayed authorization of the physician for narcotic medication orders and refills on the last QAA meeting in December 2018. The PC stated she remembered having a talk with one of the physician regarding timely authorization of the narcotic medications but did not followed up if the issue still continued to exist. The PC stated she did not ask for the Medical Director's (MD) assistance because the facility had a new MD on December 2018. On February 7, 2019, at 10:45 a.m., the ADON was interviewed. The ADON stated the facility conducted a medication reconciliation for each resident that started in December 2018. She stated she assigned licensed nurses a weekly schedule list of residents medication reconciliation to check. The ADON stated the licensed nurses would do a triple check of the resident's medication from the physician order, to the medication supply available, to the resident's electronic Medication Administration Record (eMAR). (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Some	The ADON stated for physician order discrepancy, the licensed nurses should contact the physician, if there was an issue on medication availability, the licensed nurses should order the medication needed and contact the pharmacy for follow up. The ADON stated she received the medication reconciliation report from the nurses on the weekly basis. The ADON stated there was no issue on medication availability and she made sure medications were delivered on time to be administered to the residents. The ADON stated she relied on the medication reconciliation report being given to her by the staff to know if there was an issue or concern with medication availability. The Medical Record Director (MRD) was responsible in the audits of the residents' electronic Medication Administration Record (eMAR) for completion and accuracy. The ADON stated she did not have a system to count how many resident's medication reconciliations report she receive on a weekly basis, nor to know if all residents were being checked for weekly medication reconciliation. The ADON further stated she did not have a list of what were the issues and concerns the licensed nurses were having on the residents' medication availablity from the medication reconciliation report. On February 11, 2019, at 3:15 p.m., the Medical Record Director (MRD) was interviewed. The MRD stated medical records conduct a weekly audit of all the residents eMAR. The MRD stated a copy of the weekly eMAR audit report were given to the Administrator and the Director of Nursing (DON). The MRD stated if there were missing signature in the eMAR from the audit, a copy would be given directly to the licensed nurses. The MRD stated the licensed nurses have 30 days to correct the eMAR audit and return the audit report to her. The MRD stated she had multiple eMAR audits with missing signatures but she did not have a system on tracking the total number of eMAR audits with missing signature of licensed nurses she had weekly. The MRD further stated she based the amount on the thickness of audit report copy she have to give to the licensed nurses weekly. On February 11, 2019, at 8:20 a.m., the Pharmacy Owner (PO) was interviewed. The PO stated there were several pharmacy deliveries made on the facility every day. The PO stated for STAT medication it would be delivered within one hour and for other new medication order it would be delivered within 4 hours. The PO stated he was not aware of the issues regarding the residents not receiving their medications on time due to medication unavailability as a result of delayed delivery of medications form the pharmacy. The PO further stated he was not informed the pharmacy had been having issues with the delay to get a physician's authorization to refill narcotic medications. The facility policy and procedure titled, Quality Assessment and Assurance (QAA), dated January 2018, was reviewed. The policy indicated, .The QA&A Committee oversees and identifies all efforts that improve the quality of care in the facility by monitoring performance measure, directing improvement actions, and evaluating the effectiveness of quality management activities .