STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555438	A. Building B. Wing	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kei-Ai Los Angeles Healthcare Center	2221 Lincoln Park Ave Los Angeles, CA 90031

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview, and record review, the facility failed to obtain a Physician's Order for Gastrointestinal (GI-related to stomach and intestines) consultation and follow up upon readmission for one of five sampled residents (Resident 75). This deficient practice resulted in Resident 75 not receiving timely medical services and follow up medical services per General Acute Care Hospital 1 (GACH 1) discharge instructions. Findings: A review of Resident 75's Face sheet (Admission Record) indicated the facility originally admitted Resident 75 on 3/17/2022 and was readmitted on [DATE] with diagnoses including sepsis (body's extreme response to an infection), reduced mobility and dysphagia (difficulty or discomfort in swallowing). A review of Resident 75's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 1/15/2023, indicated Resident 75 had severely impaired cognition (never/rarely made decisions). The MDS indicated the resident required extensive one person physical assist for activities of daily living (ADLs, such as transferring, bed mobility, dressing, toilet use, eating and personal hygiene). A review of Resident 75's Physician's History and Physical (H&P) dated 1/14/2023, indicated Resident 75 could make needs known but cannot make medical decisions. A review of Resident 75's Discharge Summary from GACH 1 dated 11/5/2022, indicated to schedule a follow up esophagogastroduodenoscopy (EGD- a procedure during which a small flexible tube is inserted through the mouth to the stomach to diagnose and treat problems in the food pipe and stomach) in eight weeks with GI services for Resident 75. A review of Resident 75's Physician's Orders for 11/2022 and 12/2022, did not indicate an order for GI consultation for Resident 75. During an interview on 2/16/2023 at 8:36 AM, Resident 75's Responsible Party 1 (RP 1) stated the facility did not provide Resident 75 a GI consultation despite her (RP 1) request. RP 1 stated, finally after nine months, the resident was scheduled for a GI consultation on 3/24/2023. (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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/21/23 at 1 PM, the Assistant Director of Nursing 1 (ADON 1) stated Resident 75 did not have any orders for GI consultation after re-admission from GACH 1 on 11/5/2022. ADON 1 stated, The admitting nurse must have not entered the order for a follow up consultation and EGD (Esophagogastroduodenoscopy - a procedure to diagnose and treat problems in your upper GI). ADON 1 stated the outcome was a delay in the follow up and the administration of medical care to Resident 75. During an interview on 2/21/2023 at 3:45 PM, the Director of Nursing (DON) stated admitting nurses were required to check a resident's discharge summary from the hospital and obtain orders for all the medications, and recommended follow ups from the physician. The DON stated the order for repeat EGD in eight weeks for Resident 75 was never placed in our system and it was missed. The DON stated the outcome was a delay in the follow up recommendations and the administration of medical care to Resident 75. A review of the facility's policy and procedures titled, Admission Policy, revised March 2019, indicated the company`s goal is to admit residents in which the facility staff can clinically and financially manage, while developing exceptional quality of care. One of process steps indicate to distribute admission notification to appropriate staff. This includes the following: Hospital referral, History and Physical and Hospital discharge summary. A review of the facility's policy and procedures titled, Orders for Antibiotics-Antibiotics Administration, reviewed January 2023, indicated if a resident is admitted from an emergency department, acute care facility, or other care facility, the admitting nurse will review discharge and transfer paperwork for current orders.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 111), who had a medical history of an epidural abscess (an infection inside or near the spine that requires immediate treatment) received care, treatment, and services in accordance with professional standards of practice by failing to: -Ensure discharge orders from the hospital were verified with a Medical Doctor (MD), which includes Bactrim (a medication consisting of a combination of two antibiotics, used to treat bacterial infections, one of the few antibiotics that are available to treat Methicillin-Resistant Staphylococcus Aureus [MRSA - an infection that is difficult to treat because of resistance to some antibiotics]). -Ensure Resident 111 was seen by a physician within 72 hours of admission (on [DATE]) for the initial visit and evaluation, per facility policy. -Ensure Resident 111 was evaluated by a physician at least once every 30 days for the first 90 days after admission ([DATE] - [DATE]). -Ensure Resident 111 received Rifampin (antibiotic to treat bacterial infection) on ,d+[DATE], ,d+[DATE] and [DATE]. -Ensure Resident 111 had transportation to the Infectious Disease (ID - a doctor that specializes in the treatment of infections) appointment on [DATE] and assist in re-scheduling a follow up appointment. These deficient practices caused an increased risk for Resident 111 to develop bilateral (affecting both sides) lower extremity flaccid paralysis (extreme muscle weakness), with new discitis (infection between the discs of the spine) / osteomyelitis (inflammation and swelling of the bone) at the T5-T7 (thoracic spine- upper and middle part of the back) on [DATE] and the resident expired at general acute care hospital (GACH 1) on [DATE] at 2:40 AM. On [DATE], at 12:25 PM, an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the Administrator (ADM), the Director of Nursing (DON) and the Administrator in Training, regarding the facility's failure to enter (and administer) antibiotic medications from the GACH discharge medication orders for Resident 111, who had a spinal abscess, upon admission to the facility, on [DATE]. The facility also failed to ensure transportation for Infectious Disease specialist appointment on [DATE], per GACH discharge instructions for Resident 111. On [DATE] at 5:18 PM, while onsite at the facility, the IJ was removed in the presence of the ADM and Director Staff Development (DSD), after the ADM and DON submitted an acceptable Removal Plan (interventions and implementation to correct the deficient practices) which was verified and confirmed through observation, interview and record review. The acceptable removal plan was as follows: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Clinical Research Nurse, DSD / Designee conducted a series of in-service, trainings and re-education on [DATE] to staff regarding the purpose and importance of making advance arrangements of transportation to meet resident's appointments and purpose and the importance of reviewing hospital discharge instructions are entered and carried out. This training will continue until all responsible staff are captured. -Resident clinical records will be reviewed by the Interdisciplinary Team (IDT - a team of professionals who plan, coordinate, and deliver personalized health care) and the Medical Records Designee will audit resident admission records to ensure interfacility transfer reports, including facility admission orders 24 hours after resident admission daily five times a week, audit report will be presented to the clinical meeting for follow up. -Medical Records will print the appointment records daily from the last ,d+[DATE] hours to be reviewed at the clinical meeting. Licensed Nurse / designee will attempt to reschedule missed appointments and re-evaluate resident for urgent medical needs. The IDT will follow up any missed clinical appointments and will remain on the IDT clinical meeting agenda until resolved. -Assistant Director of Nursing will randomly audit the clinical records of residents admitted within the seven-day period for completeness of reconciliation of admission orders. -Medical and ancillary appointments ordered on admission or newly prescribed resident appointments will be inputted and transmitted electronically into the facility's Smart Sheet system to ensure that appointments will be coordinated to other departments responsible. Once confirmed, the scheduled appointment and transportation will send an automatic reminder to designated staff or department at least five days prior, so the scheduled appointment will not be missed. Licensed Nurse / Designee with document the communication process in the resident's clinical record. -In the event that a medical appointment is missed, the facility has vans and multiple vendor partners that will be used to fulfill transportation requests. Facility will use its own vans to complete the trip as soon as possible. -Administration / Designee will randomly track the appointment records inputted in the Smart Sheet system three times a week for three weeks, then randomly two times per week thereafter. This will be adopted as a performance measure and discussed during regularly scheduled Quality Assurance and Performance Improvement (QAPI) meetings. Findings: A review of Resident 111's Discharge Documentation from GACH 1, dated [DATE], signed by the Internal Medicine doctor (MD 4) indicated the resident was discharged from GACH 1 to the facility and the discharge action plan included: -Continuing antibiotics for an epidural infection and follow-up with Infectious Disease for the treatment course. -New prescription antibiotic medications of Rifampin (used to treat bacterial infections) 300 milligrams (mg), two capsules orally once a day before a meal; and Bactrim DS two tablets orally every eight hours. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A Follow-up appointment with Infectious Disease on [DATE] at 1 PM. A review of Resident 111's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including hemiplegia (paralysis of one side of the body) following a cerebral infarction (also known as a stroke which occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), Type II diabetes (when the body doesn't use insulin properly leading to usually high levels of blood sugar), scoliosis (curvature of the spine), extradural and subdural abscess (serious infection that develops in the space between the bones of the spine), hypertension (high blood pressure), and resistance to multiple antibiotics. The Admission Record further indicated Resident 111 was self-responsible. A review of Resident 111's Progress Note dated [DATE] at 3 PM, indicated the resident was able to verbalize her needs in English, and was alert and oriented to self, date, and place at the time of admission despite her underlying diagnoses. A review of the Physician's Order Summary Report dated [DATE] to [DATE], indicated Resident 111 was to receive: -Infectious Disease appointment on [DATE] at 1 PM. -Rifampin Oral Capsule 300 mg, give two capsules by mouth one time a day for epidural abscess. The Physician's Order Summary Report indicated there was no order for the antibiotic Bactrim and that the orders were signed and dated by Nurse Practitioner (NP 1) on [DATE] (the day of admission), not the MD. A review of Resident 111's Medication Administration Record (MAR) dated [DATE] to [DATE], indicated there was no documentation that the resident received Bactrim. A review of Resident 111's MAR dated [DATE], indicated Resident 111 did not receive Rifampin on , d+[DATE], ,d+[DATE] or [DATE]. The MAR indicated Resident 111 received her first and only dose of Rifampin on [DATE]. A review of Resident 111's Interdisciplinary Team (IDT) Discussion - Infection document dated [DATE], indicated Resident 111 was admitted on Rifampin 300 mg two capsules daily for epidural abscess without any adverse reaction noted. Further review of the IDT document indicated the Bactrim antibiotic was not mentioned. A review of Resident 111's Care Plan initiated on [DATE], indicated the resident had an epidural abscess, with a care plan goal of no signs and symptoms of active infection. The care plan interventions included Rifampin two capsules by mouth one time a day (Bactrim was not indicated), offering and encouraging the intake of fluids, administering medications as ordered, vital signs every shift until antibiotic/anti-infectives were completed, monitoring for side-effects from antibiotic therapy such as nausea, vomiting, diarrhea, and notifying the physician. The interventions also indicated to report to the physician any worsening signs and symptoms of infection or lack of improvement from treatment, encouraging good clean hygiene techniques to avoid cross-contamination. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 111's Progress Note dated [DATE] at 5:13 PM, indicated the resident had a physical medicine rehabilitation consult for mobility, activities of daily living (ADL) impairment, weakness, and debility (physical weakness) secondary to bacteremia (presence of bacteria in the blood stream) and epidural abscess/discitis now with generalized weakness and total dependence for ADLs. The note further indicated Resident 111 had pain in her back and down her right leg and had difficulty moving her right leg. A review of Resident 111's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated [DATE], indicated the resident had moderately impaired cognition (decisions poor; cues/supervision required), required extensive assistance and two-person physical assistance for bed mobility, and required extensive assistance and one-person physical assistance for dressing, eating, toilet use, and personal hygiene. A review of Resident 111's Medication Administration Record (MAR) dated from [DATE] to [DATE], indicated the resident did not receive any as needed doses of Tylenol (medication used to relieve mild pain). A review of Resident 111's Medication Administration Record dated [DATE] to [DATE], indicated there was no documentation that the resident received Bactrim. A review of Resident 111 IDT Discussion - Care Meeting document dated [DATE], indicated the resident's medication regime was reviewed and all admission orders were followed and carried out, as needed with the pharmacy consultant and nursing. The IDT Discussion Care meeting document indicated nursing staff would notify the Medical Doctor (MD 1) for any change in condition (COC) and that it was signed by NP 1 on [DATE], The IDT Discussion - Care Meeting document did not include Bactrim antibiotic. A review of Resident 111's Medical Progress Notes dated [DATE], indicated the resident had no recent events or change in condition, and indicated it was signed by NP 1, not the MD. A review of Resident 111's Progress Note dated [DATE] at 1:46 PM, indicated the resident did not go to her infectious disease (ID) appointment due to transportation and the desk nurse was working on rescheduling the appointment. No additional information was documented. A review of Resident 111's Physician's Telephone Orders dated [DATE] at 2 PM, indicated a telephone order from NP 1 was received indicating the MD was notified of the resident's missed ID appointment and the MD ordered to re-schedule the ID appointment on or before [DATE]. A review of Resident 111's MAR dated from [DATE] to [DATE], indicated the resident received Percocet (medication used to relieve moderate to severe pain) ,d+[DATE] mg twice a day in addition to 16 doses of Percocet ,d+[DATE] mg and 27 doses of Percocet ,d+[DATE] mg as needed for pain. A review of Resident 111's Medical Progress Notes dated [DATE], indicated it was signed by NP 1, not the MD. The medical progress note was illegible and unable to determine Resident 111's current health status. A review of Resident 111's medical record indicated there were no other medical progress notes documented in the resident's medical record. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 111's Progress Note dated [DATE] at 12:43 PM, indicated the resident reported numbness in both of her legs and the inability to move both her legs which was associated with feeling nauseous and lethargic (drowsy). The Progress Note indicated the resident's right sided back pain remained and recommendations from MD 2 (Rehabilitation Physician) was to discuss with the primary team about transferring Resident 111 back to the hospital for evaluation given new acute onset weakness and numbness in bilateral lower extremities, lethargy, and prior history of lumbar epidural abscess on Magnetic Resonance Imaging (MRI- a procedure that uses radio waves, a powerful magnet, and a computer to make a series of detailed pictures of areas inside the body) of left spine during last admission. A review of Resident 111's MAR dated from [DATE] to [DATE], indicated the resident had a pain management consult due to increased radiating pain to the right thoracic back, and received Percocet , d+[DATE] mg twice a day, Baclofen (medication used to treat muscle spasms) 5 mg for lower back muscle spasms, two as needed doses of Percocet ,d+[DATE] mg and one as needed dose of Percocet ,d+[DATE] mg. A review of Resident 111's Situation, Background, Assessment, Recommendation (SBAR - a tool used to gather information and communicate with a healthcare professional) Communication Form dated [DATE], indicated the facility received a call from NP 1 indicating MD 2 noticed Resident 111 more weaker than usual. The recommendations from NP 1 were to transfer Resident 111 to GACH 1 for further revaluation due to an increase in bilateral lower extremity weakness. A review of Resident 111's GACH 1 Emergency Documentation dated [DATE] at 8:20 PM, indicated the resident was readmitted to GACH 1. A review of Resident 111's GACH 1 Consultation Note dated [DATE] indicated the resident reported the inability to move her legs accompanied by decreased sensation (ability to feel) below her waist since waking up on [DATE]. The Consultation Note further indicated that per Resident 111, she had been intermittently compliant with her antibiotics due to not receiving them every day at the facility. The note indicated Resident 111 had informed the facility about her new leg weakness that started on [DATE], but the facility decided to bring her to GACH 1 on [DATE]. A review of Resident 111's GACH 1 History and Physical Report dated [DATE] at 10:42 PM, indicated Resident 111 reported receiving antibiotics inconsistently since residing at the facility, The report indicated Resident 111 was discharged on oral Bactrim and Rifampin, but with questionable adherence at the facility. The History and Physical further indicated Resident 111 had bilateral lower extremity flaccid paralysis (extreme muscle weakness), with the MRI showing new discitis / osteomyelitis (inflammation and swelling of the bone) at T5-T7 (thoracic spine- upper and middle part of the back) with epidural phlegmon extension resulting in cord compression and suspected cord edema (spinal cord swelling). A review of Resident 111's GACH 1 Consultation Note dated [DATE] at 11:22 AM, indicated Resident 111 had a previous admission to GACH 1 on [DATE] to [DATE], was found to have persistent MRSA bacteremia and lumbar epidural abscess. The Consultation Note further indicated Resident 111 was discharged on oral Bactrim and Rifampin to the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:42 PM, RNS 7 stated he was working on [DATE] on the 3 PM to 11 PM shift. RNS 7 stated the Discharge Documentation from GACH 1 indicated Resident 111 should have been receiving both Bactrim and Rifampin while at the facility. RNS 7 stated Resident 111 did not have any orders for Bactrim in their medical record, and further stated the MAR for ,d+[DATE], ,d+[DATE], and ,d+[DATE] also did not indicate Resident 111 received Bactrim during the resident's time at the facility. RNS 7 stated the medication list from GACH 1 should be checked and verified with the MD on admission. RNS 7 stated maybe he missed or failed to put the order in the system, and that he should be double checking. RNS 7 stated Resident 111 not receiving Bactrim could cause possible harm because the resident had sepsis (a body's response to an infection, which can be life threatening). A review of Resident 111's Death Summary from GACH 1 dated [DATE] indicated on [DATE] the resident was noted to have hypotension (low blood pressure) that was not responsive to intravenous fluid (special formulated fluid injected into a vein to help keep blood pressure in normal range), noted to have a decrease in her mentation, and elevated lactate level of 6.8 (normal range 0XXX,d+[DATE], can be caused by septic shock, a life-threatening condition that happens when your blood pressure drops to a dangerously low level after an infection) and white blood cell (WBC - help the body fight infection and disease, normal levels 4.5 to 11) count of 43. The death summary indicated after discussion with Resident 111's friend, the resident was changed to a code status of Do not Resuscitate (DNR) and was moved to the Medical Intensive Care Unit (MICU - a unit in the hospital for patients who need critically intensive care) due to likely septic shock. Overnight Resident 111, became more hypotensive and it was determined that the risks of surgery outweighed the benefits, posing unreasonable discomfort to the resident without being able to address the underlying bacteremia or source control; ultimately causing unnecessary and prolonged suffering. The decision was made to transition Resident 111 to comfort measures only (medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort). Resident 111 passed on comfort care at 2:40 AM on [DATE]. During a telephone interview on [DATE] at 10:13 AM, Licensed Vocational Nurse (LVN) 15 stated that she was working at the facility on [DATE] (missed ID appt) during the 7 AM to 3 PM shift. LVN 15 stated transportation did not show up to the facility to take Resident 111 to her follow up appointment. LVN 15 stated she then asked the desk nurse to work on rescheduling the resident's ID appointment. LVN 15 stated she did not remember who the desk nurse was at the time but stated she did not receive an update regarding the rescheduling of Resident 111's appointment. During an interview on [DATE] at 10:49 AM, Registered Nurse Supervisor (RNS) 3 stated there was no documentation in Resident 111's medical record indicating the ID appointment was rescheduled (after almost one month). During a telephone interview on [DATE] at 11:40 AM, Charge Registered Nurse (CRN) 1 stated she worked for Infectious Disease at GACH 1 and that Resident 111 did not show up for her appointment on [DATE] at 1 PM, and the appointment was not rescheduled. During an interview on [DATE] at 12:35 PM, NP 2 (who directly worked with the facility Medical Director) stated for newly admitted residents, the policy was the physician would perform the initial visit and would review and reconcile the resident's medications. NP 2 stated the NP would perform the follow-up visits and if a resident was coming from a GACH with antibiotics, the antibiotics would be continued at the facility, because you would not want the infection to become worse. NP 2 stated the only time antibiotics from the hospital would be discontinued was if the resident has an allergy. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 1:13 PM, a call was made to MD 1's office. MD 1 was unable to be reached. The office receptionist indicated that NP 1 was to be contacted for information and could not provide any additional contact information for MD 1. During a telephone interview on [DATE] at 2:09 PM, NP 1 stated she saw Resident 111 on admission when the resident was admitted to the facility on [DATE]. NP 1 stated she told staff to continue all of Resident 111's medications from the hospital especially antibiotics because the resident was a special case. NP 1 stated she informed staff to continue all medications from GACH 1 until Resident 111 was seen and followed up with the ID physician. During an interview on [DATE] at 3:31 PM, MD 3 stated she was the Medical Director for the facility and that when a resident was admitted to the facility the nurses call her and go over the resident's discharge summary, history and physical, and medications. MD 3 stated physicians reconcile resident's medication because how can a nurse decide to start or stop something. MDs were always the one to give admission orders, and stated she did not think consulting an NP for continuing orders from GACH was appropriate, but she was not aware of what occurred in this case. MD 3 stated Resident 111's Discharge Documentation indicated the resident was to continue Bactrim and Rifampin at the facility and it did not look like Resident 111 received Bactrim at the facility only Rifampin. MD 3 stated if a resident were to miss a month and a half of Bactrim, it was possible the resident's condition could worsen. During an interview on [DATE] at 5:16 PM, with the Director of Nursing (DON), Resident 111's medical record was reviewed. The DON stated and confirmed NP 1's signature was documented on the resident's History and Physical, Order Summary Report dated [DATE] to [DATE], the IDT Discussion - Care Meeting, and the Medical Progress Notes dated [DATE], and [DATE]. The DON confirmed there were no other medical progress notes in the resident's medical record. The DON stated, according to the documentation MD 1 did not see the resident; NP 1 did. The DON stated NP 1 saw and verified Resident 111's orders on admission. The DON stated it had always been the facility's practice to verify orders with the physician. The DON stated the facility failed to have a physician see Resident 111 timely after admission, and the facility failed to verify admission orders with MD. The DON stated, if there was difficulty reaching the MD, staff should have gone up the chain of command and notified the Medical Director. A review of the facility's policy and procedure titled, Administrative Manual, Physician Services, revised , d+[DATE], indicated a physician will personally approve in writing a recommendation that an individual be admitted to a facility. Physicians were expected to comply with all the state and federal regulations and accepted tenets of professional practice, facility policies and practices including state and federal requirements for documentation related to supervision and management of care and to support reimbursement. For the initial physician visit the attending physician will: be notified by the facility immediately upon the arrival of his resident at the facility; personally approve in writing a recommendation that an individual be admitted to a facility, verify orders upon admission with the licensed nursing personnel, state the diagnoses, prescribe medications, treatments, rehabilitative services, diet, special procedures, diagnostic tests, restraints, and any other orders for care as specified by the physician, inform the resident of his/her medical condition, treatments/medications, risks/benefits, and alternatives, and indicate resident capacity for decision-making; including a written report of a history and physical examination within seventy-two (72) hours after admission or within five (5) days prior to admission. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The residents in a skilled nursing facility must be seen by a physician within 72 hours of admission for the initial visit and evaluation and at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter, unless the resident's condition requires more frequent visits, or an alternate schedule of visits is deemed appropriate. A review of the facility policy and procedure titled, Physician Visits, reviewed ,d+[DATE], indicated the attending physician will visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems that cannot be handled readily by phone. The attending physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. A review of the facility's Policy and Procedure titled, Telephone Orders, reviewed ,d+[DATE], indicated Verbal telephone orders may only be received by licensed personnel. Orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record. The entry must contain instructions from the physician, date, time, and the signature and title of the person transcribing the information. Telephone orders must be countersigned by the physician during his or her next visit. A review of the facility's Policy and Procedure titled, Admission Assessment and Follow-up: Role of the Nurse, revised ,d+[DATE] indicated reconcile the list of medications from the medication history, admitting orders, the previous MAR (if available), and the discharge summary from the previous institution, according to established procedures. Contact the attending physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. A review of the facility's policy and procedure titled, Transportation, revised [DATE], indicated the facility shall help arrange transportation for residents as needed. Social Services and/or nursing services will help the resident as needed to obtain transportation.

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	555438	A. Building B. Wing	02/21/2023

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36395 Based on interview and record review, the facility failed to ensure medical records were complete and accurately documented in accordance with accepted professional standards and practices for two of 35 sampled residents (Resident 111 and Resident 162). -For Resident 111, the facility failed to ensure licensed staff did not falsify the Medication Administration Record (MAR - a record of all medication administered to a resident) to indicate seven doses of rifampin (a medication used to treat infection) 300 milligrams (mg - a unit of measure for mass) were administered when it was unavailable between 12/31/2022 and 2/7/2023. -For Resident 162, who had an abdominal x- ray on 1/12/2023 indicating ileus (temporary lack of normal muscle contractions of the intestines), the facility failed to ensure the notification of the physician or nurse practitioner (NP) was accurately documented in the medical record. These deficient practices of documenting in the MAR that medication was given when it was unavailable could have led to a worsening of Resident 111's medical condition due to medication not administered per the physician's orders, could mislead medical providers to prescribe a higher than necessary dose of rifampin causing more side effects and leading to Resident 111 experiencing a diminished quality of life. These deficient practices also failed to communicate health services rendered to Resident 162 among the health care team. Findings: a. A review of Resident 111's Admission Record dated 2/21/2023, indicated the resident was admitted to the facility on [DATE] with diagnoses including extradural and subdural abscess (an infection near the spine that usually results from a nearby bone infection.) A review of Resident 111's Order Summary Report (a summary of all active physician orders), dated 1/31/2023, indicated Resident 111's physician prescribed rifampin 300 mg to give two capsules by mouth one time a day for epidural abscess. A review of Resident 111's MAR, dated December 2022, indicated Resident 111 received one dose of rifampin in December 2022. A review of Resident 111's MAR, dated January 2023, indicated Resident 111 received 28 doses of rifampin in January 2023. A review of Resident 111's MAR, dated February 2023, indicated Resident 111 received six doses of rifampin in February 2023 before she was re-hospitalized on [DATE]. A review of the pharmacy delivery manifest indicated the pharmacy made four deliveries of rifampin 300 mg each containing 14 capsules (a seven-day supply) on the following dates: 12/28/2022, 1/5/2023, 1/16/2023, 1/26/2023. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 2/17/2023 at 9:38 AM with Pharmacy Representative 1 (PR 1), PR 1 stated the rifampin 300 mg on the pharmacy delivery manifest was for Resident 111. PR 1 stated the pharmacy delivered a seven-day supply of rifampin 300 mg for Resident 111 on 12/28/2022, 1/5/2023, 1/16/2023, and 1/26/2023. PR 1 stated the facility requested the refills from the pharmacy on the same dates they were delivered. PR 1 stated the next refill would have been due to fill on 2/2/2023, but it was never requested by the facility. PR 1 stated the pharmacy only delivered a total of 28 doses of the rifampin 300 mg for Resident 111. During an interview on 2/21/2023 at 9:04 AM with the Registered Nurse Supervisor (RNS 3), RNS 3 stated she was the nurse supervisor for the third floor and supervised the Licensed Vocational Nurses (LVNs) who provide treatments and pass medications for residents on this floor. RNS 3 stated there was one dose of rifampin signed as administered for Resident 111 in December 2022, and there were 28 doses of rifampin signed as administered for Resident 111 in January 2023, and six doses in February 2023, however the pharmacy only made four deliveries of seven-day supplies each. RNS 3 stated that if the MAR was signed for 35 doses but the pharmacy only delivered 28 doses, it was likely that some of the licensed staff administering medications signed the MAR that they administered rifampin to Resident 111 without having the medication available in the building. RNS 3 stated the facility had no other supply of rifampin 300 mg capsules from an e-kit (emergency medication kits), an automated drug dispensing cabinet, or any other source, so it must be ordered from the pharmacy to be available for the resident. RNS 3 stated rifampin was a medication meant to treat Resident 111's epidural abscess infection. RNS 3 stated the failure of licensed staff to administer rifampin regularly could have contributed to the worsening of Resident 111's epidural abscess which led to her being re-hospitalized . RNS 3 stated the MAR may not accurately reflect the care delivered to Resident 111 due to licensed staff signing for more administration of rifampin doses than the doses of medication available in the facility. RNS 3 stated this might put the resident at risk of her condition worsening further, or the physician increasing the dose due to the illusion that it may not be working at its current dose. RNS 3 stated giving more medication that needed to adequately treat the resident's medical condition may cause adverse effects which could lead to a diminished quality of life. b. A review of Admission Record indicated the facility admitted Resident 162 on 10/12/2022 with diagnoses including cerebrovascular disease (CVA, stroke) with right hemiplegia (paralysis of right side of the body) and metabolic encephalopathy (a condition in which the brain function is disturbed temporarily or permanently due to different diseases or toxins in the body). A review of the Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 10/16/2022, indicated Resident 162 was disoriented to year, month, and day. Resident 162 needed one-person physical assistance with dressing, eating personal hygiene, bathing and two or more-person physical assistance with bed mobility and toilet use. A review of the abdominal x-ray dated 1/11/2023 indicated Resident 162 had mild to moderate ileus. During an interview on 2/21/2023 at 8:48 AM, MDSC 2 stated Resident 162 had abdominal x-ray done on 1/11/2023 with the result indicating ileus. MDSC 2 was unable to find documentation that the physician was notified about the result. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/21/2023 at 10:28 AM, RNS 2 stated the nurse practitioner (NP 1) was notified on 2/12/2023 at 10 AM by text message. RNS 2 stated the NP 1 replied no new orders by text message. RNS 2 stated the NP 1 notification should be documented in Resident 162 notes. During an interview on 2/21/2023 at 12:28 PM, the director of nursing (DON) stated she was unable to find documentation that NP 1 was notified of the abdominal x-ray result. The DON stated if the NP or the physician were notified, the notification should be documented in Resident 162's record. A review of the facility's policy titled, Health Information Record Manual, last revised 1/26/2023, indicated a health record will be maintained for each resident admitted to the nursing facility . Contains an accurate and functional representation of the actual experience of the individual in the facility . The health record will be accurate . Medication and Treatment Administration (MAR) . Licensed nurses will be responsible for: . Medication and treatment administered and recorded as prescribed. A review of the facility policy titled, Charting and Documentation, revised on 7/2017 and reviewed on 1/2023 indicated all services provided to the resident, progress toward the care plan goals or any changes in the resident's medical, physical, functional, or psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections when the following occurred: -The oxygen cannula (a flexible tube with two prongs that deliver oxygen directly into the nostrils) was observed exposed hanging less than four inches from the ground for one of two sampled residents (Resident 252). -The urinary drainage bag was not kept off the floor for one of two sampled residents (Resident 260). -Licensed Vocational Nurse (LVN) 17 was observed wearing a surgical mask while working in the same unit with residents who had been confirmed positive for COVID-19 (an infectious disease caused by the SARS-CoV-2 virus). These deficient practices had the potential to result in the contamination of resident's care equipment and place residents and staff at risk for COVID-19. Findings: a. A review of Resident 252's Admission Record indicated admitting diagnoses of coronavirus disease 2019 (COVID-19), pneumonia (lung infection caused by bacteria, viruses, or fungi), and chronic obstructive pulmonary disease (COPD-a long-term lung disease that makes it hard to breathe) with emphysema (gradual damage of lung tissue). A review of the Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 11/25/22, indicated Resident 252 required extensive, two-plus person physical assistance from staff for various activities of daily living (ADL). During an interview on 2/14/2023 at 9:24 AM, Resident 252's family member stated Resident 252 received oxygen through an oxygen cannula and stated, [the oxygen cannula] is on the ground a lot. I have to pick it up off the ground sometimes. I've never seen the staff change it. During an observation on 2/14/2023 at 9:41 AM, Resident 252's oxygen cannula was draped on top of an oxygen concentrator (a medical device that gives you extra oxygen) at the bedside. The prongs (the part of the tubing that is placed in the nostrils) were exposed and hanging less than four inches from the ground. The prongs were touching the back of the oxygen concentrator, and the oxygen cannula did not have a label to indicate the date it was last changed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview in Resident 252's room on 2/14/2023 at 9:56 AM, Registered Nurse Supervisor (RNS) 2 assessed the oxygen cannula and stated, I don't see a label on it, and RNS 2 could not verify the date the cannula was last changed or was due to be changed. RNS 2 then stated the nasal cannula was supposed to be changed every week and stated, I'm going to have to change it today. RNS 2 also stated the facility policy was to store the oxygen cannula in a plastic bag when not in use. RNS 2 confirmed the oxygen cannula was not stored per facility policy, and stated, there should be a bag. It goes into his [nostrils], so we don't want it touching dirty surfaces. RNS 2 further stated it could be an infection risk to Resident 252 if the cannula was left exposed. During an observation in Resident 252's room on 2/15/2023 at 9:22 AM, Resident 252's oxygen cannula was hanging from the bedside rail with the prongs exposed. The tubing was not stored in a plastic bag. During an interview on 2/15/2023 2:29 PM, RNS 2 stated, [the oxygen cannula] should be in a bag and confirmed there was a storage bag in the room, but it was not being used. When asked about the risks associated with leaving the oxygen cannula exposed, RNS 2 stated, Well it can pick up bacteria, and it goes in his [nostrils], adding that Resident 252 could then develop a respiratory infection. A review of Resident 252's physician orders dated 1/12/2023 indicated an active order for staff to Change oxygen cannula tubing [every] week every Sunday and [as needed] for soilage A review of the facility policy and procedure (P&P) titled, Departmental (Respiratory Therapy) - Prevention of Infection, dated 11/2011, indicated the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment .among residents and staff. Keep the oxygen cannula and tubing used [as needed] in a plastic bag when not in use. b. A review of Resident 260's Admission Record indicated the facility admitted the resident on 9/28/2022 with diagnoses including dysphagia (difficulty swallowing), encounter of attention to gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), and retention of urine (inability to completely or partially empty the bladder). A review of Resident 260's MDS, dated [DATE], indicated the resident was cognitively (relating to thinking, reasoning, or remembering) severely impaired (never/rarely made decisions). The MDS also indicated the resident required extensive assistance with one person assist for bed mobility, transfer, and toileting. A review of Resident 260's, Physician Order, dated 10/6/2022, indicated urinary catheter (a hollow flexible tube maintained within the bladder for the purpose of continuous drainage of urine), 14 French (Fr -size of the catheter), connected to a bedside drainage bag (to collect urine) indication of use urinary retention (inability to completely or partially empty the bladder). A review of Resident 260's Care Plan, revised on 10/7/2022, for high risk for developing complications including urinary tract infection (UTI - an infection in any part of the urinary system [kidneys, bladder or urethra]), due to use of urinary catheter related to urinary retention, indicated to observe possible complications of catheter use such as urinary tract infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/13/2023 at 2:32 PM, with Licensed Vocational Nurse (LVN) 11, in Resident 260's room, Resident 260's urinary catheter drainage bag was observed touching the floor. LVN 11 confirmed Resident 260's urinary catheter drainage bag was touching the floor. LVN 11 stated it is important the urinary catheter drainage bag is not touching the floor for infection control. During an interview on 2/16/2023 at 2:10 PM, the Director of Nursing (DON) stated urinary catheters and drainage bags were not supposed to touch the floor for infection control. She stated if the urinary catheter and drainage bag was touching the floor there would be a risk for infection for residents with urinary catheters. A review of the facility's policy revised 2023 titled, Catheter Care, Urinary, indicated be sure the catheter tubing and drainage bag are kept off the floor. c. During an observation, on 2/16/2023, at 9 AM, LVN 17 was observed wearing a surgical mask. During a concurrent interview, LVN 17 stated she was unaware that she was supposed to wear an N95 respirator (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) while working on the floor with residents that were confirmed with COVID-19. LVN 17 stated it was important to wear an N95 respirator while working on the floor with residents that were confirmed with COVID-19 to protect both herself and the residents from infection from COVID-19. During an interview with the Infection Preventionist (IP), on 2/17/2023, at 12:07 PM, the IP stated staff have to wear an N95 respirator in the COVID-19 unit to prevent infection from COVID-19. The IP further stated there were currently two residents on isolation for COVID-19. A review of the facility's policy titled, Infection Prevention and Control Program, reviewed 1/2023, indicated an infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. The P&P further indicated those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment (PPE) and the facility provides PPE and checks for its proper use.