STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555738	A. Building B. Wing	07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

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 0697 Level of Harm - Actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45579 Based on observation, interview, and record review, the facility failed to ensure three of five sampled residents (Resident 1, Resident 2, and Resident 3), who were at risk for pain, received care and services in accordance with professional standards of practice and the comprehensive person-centered care plan by failing to: 1. Administer Resident 1 ' s Oxycodone Hydrochloride (Oxycodone HCL- medication to treat pain) and Morphine Sulfate (medication used to treat pain) as scheduled and prescribed by the Attending Physician and reevaluating the resident ' s pain after administering pain medications as per facility policy. 2. Administer Resident 2 ' s Hydrocodone- Acetaminophen (Norco- medication to treat pain) as scheduled and prescribed by the Attending Physician and reevaluating the resident ' s pain after administering pain medications as per facility policy. 3. Administer Resident 3 ' s Methadone (medication to treat pain) as scheduled and prescribed by the Attending Physician This deficient practice of not administering pain medications at the prescribed time caused Resident 1, Resident 2, and Resident 3 to experience severe untreated pain (pain rated at seven [7] or higher out of 10, on a pain scale from zero to ten where ten is the worst possible pain) between 5/2022 and 6/2022. Findings: A. A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic gout (a form of arthritis [joint inflammation] characterized by severe pain, redness, and tenderness in joints.) and diabetic mellitus (the body ' s inability to control sugar in the blood). A review of Resident 1 ' s History and Physical (H & P), dated 11/25/2021, indicated Resident 1 had the capacity to understand and make decisions. The History and Physical indicated Resident 1 had diagnoses that included osteoarthritis (when the protective cartilage that cushions the ends of the bones wears down over time resulting in pain) and chronic pain syndrome (pain that lasts from weeks to years). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0697 Level of Harm - Actual harm Residents Affected - Some	A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/1/2022, indicated Resident 1 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated that Resident 1 only required staff assistance with setting up for toilet use. A review of Resident 1 ' s Physician ' s Order, indicated the following orders: 1. Oxycodone Hydrochloride (Oxycodone HCL- medication to treat pain) 30 milligrams (mg- a unit of measure), give two tablets by mouth every four hours for severe pain, hold of respiratory rate (RR -normal range of breaths are from 12 to 20 respirations per minute) below 12 or sedated, order start date of 11/25/2021. 2. Morphine Sulfate (medication used to treat pain) Extended Release (ER, the pill is made so that the drug is released slowly over time) tablet extended release 60 mg. give one tablet by mouth every 12 hours related to chronic gout, give with 30 mg. to equal 90 mg., hold medication and notify Medical Doctor (MD) if RR is below 12, order start date of 5/04/2022. 3. Morphine Sulfate ER tablet extended release 30 mg., give one tablet by mouth every 12 hours related to chronic gout, give with 60 mg. to equal 90 mg. hold medication and notify MD if RR is below 12, order start date of 5/4/2022 A review of Resident 1 ' s Care Plan titled, Acute/Chronic Pain, dated 3/08/2022 and revised 6/17/2022, indicated Resident 1 will verbalize adequate relief of pain or resident will not have an interruption in normal activities due to pain. Interventions indicated were to administer analgesia (pain medications) as per physician ' s orders, evaluate the effectiveness of pain interventions and review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. During a concurrent observation and interview on 6/16/2022 at 12:54 p.m., observed Resident 1 sitting on his bed in his room grimacing (twisting of the facial features into an unpleasant expression) while moving. Resident 1 reported his pain was 8/10 during the interview and stated that he had just received his ordered pain medication. Resident 1 stated that since his admission into the facility, there have been multiple instances where in the licensed nurses provide his scheduled pain medication late. Resident 1 stated that on 6/16/2022, he was supposed to receive a dose of Oxycodone HCl 60 mg at 4:00 a.m., but the nurses did not administer the medication until almost 6:00 a.m. Resident 1 stated that because of the delay in receiving his pain medications timely, he was left in excruciating pain that morning. Resident 1 stated that the pain would be so excruciating that he is not able to conduct activities of daily living. Resident 1 stated that there were even episodes where he was in so much pain that he defecated (bowel movement) on himself. Resident 1 stated that this upset him because he has control of his bowel movements. During an interview on 6/17/2022 at 3:10 p.m. with Resident 1, Resident 1 stated that his scheduled 4:00 a. m. scheduled pain medications were always given past the scheduled time. Resident 1 stated he has received the medications after 5:00 a.m. on multiple occasions. Resident 1 stated he told the Licensed Nurses and Director of Nurses (DON) and that he just wants to receive his pain medications on time so that he will not suffer in pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	A review of Resident 1 ' s Medication Administration Record (MAR) Details for 5/2022 and 6/2022 indicated that Resident 1 ' s order for Oxycodone HCL 60 mg was not followed as per the physician ' s order as evidenced by being administered outside of the scheduled time: 1. On 5/03/2022, the 12:00 a.m. dose was documented as administered at 06:34 a.m. 2. On 5/03/2022, the 04:00 a.m. dose was documented as administered at 06:34 a.m. 3. On 5/03/2022, the 08:00 a.m. dose was documented as administered at 09:12 a.m. 4. On 5/04/2022, the 12:00 a.m. dose was documented as administered at 06:30 a.m. 5. On 5/04/2022, the 04:00 a.m. dose was documented as administered at 06:30 a.m. 6. On 5/04/2022, the 04:00 p.m. dose was documented as administered at 05:12 p.m. 7. On 5/05/2022, the 12:00 a.m. dose was documented as administered at 05:56 a.m. 8. On 5/05/2022, the 04:00 a.m. dose was documented as administered at 05:56 a.m. 9. On 5/06/2022, the 12:00 a.m. dose was documented as administered at 06:30 a.m. 10. On 5/05/2022, the 04:00 a.m. dose was documented as administered at 06:30 a.m. 11. On 5/06/2022, the 12:00 a.m. dose was documented as administered at 06:30 a.m. 12. On 5/06/2022, the 04:00 a.m. dose was documented as administered at 06:30 a.m. 13. On 5/06/2022, the 04:00 p.m. dose was documented as administered at 05:10 p.m. 14. On 5/07/2022, the 12:00 a.m. dose was documented as administered at 06:30 a.m. 15. On 5/07/2022, the 04:00 a.m. dose was documented as administered at 06:30 a.m. 16. On 5/10/2022, the 12:00 a.m. dose was documented as administered at 06:02 a.m. 17. On 5/10/2022, the 04:00 a.m. dose was documented as administered at 06:02 a.m. 18. On 5/11/2022, the 12:00 a.m. dose was documented as administered at 06:35 a.m. 19. On 5/11/2022, the 04:00 a.m. dose was documented as administered at 06:35 a.m. 20. On 5/12/2022, the 12:00 a.m. dose was documented as administered at 06:30 a.m. 21. On 5/12/2022, the 04:00 a.m. dose was documented as administered at 06:30 a.m. 22. On 5/12/2022, the 04:00 p.m. dose was documented as administered at 05:09 p.m. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	23. On 5/13/2022, the 12:00 a.m. dose was documented as administered at 05:43 a.m. 24. On 5/13/2022, the 04:00 a.m. dose was documented as administered at 05:43 a.m. 25. On 5/13/2022, the 12:00 a.m. dose was documented as administered at 05:43 a.m. 26. On 5/13/2022, the 04:00 a.m. dose was documented as administered at 05:43 a.m. 27. On 5/15/2022, the 08:00 p.m. dose was documented as administered at 10:59 p.m. 28. On 5/16/2022, the 12:00 a.m. dose was documented as administered at 02:38 a.m. 29. On 5/17/2022, the 12:00 a.m. dose was documented as administered at 06:28 a.m. 30. On 5/17/2022, the 04:00 a.m. dose was documented as administered at 06:28 a.m. 31. On 5/17/2022, the 08:00 a.m. dose was documented as administered at 11:39 a.m. 32. On 5/18/2022, the 12:00 a.m. dose was documented as administered at 07:29 a.m. 33. On 5/18/2022, the 04:00 a.m. dose was documented as administered at 07:29 a.m. 34. On 5/19/2022, the 12:00 a.m. dose was documented as administered at 06:31 a.m. 35. On 5/19/2022, the 04:00 a.m. dose was documented as administered at 06:31 a.m. 36. On 5/20/2022, the 12:00 a.m. dose was documented as administered at 01:37 a.m. 37. On 5/20/2022, the 04:00 a.m. dose was documented as administered at 06:45 a.m. 38. On 5/20/2022, the 04:00 p.m. dose was documented as administered at 05:02 p.m. 39. On 5/21/2022, the 12:00 a.m. dose was documented as administered at 01:47 a.m. 40. On 5/21/2022, the 08:00 p.m. dose was documented as administered at 09:07 p.m. 41. On 5/22/2022, the 12:00 a.m. dose was documented as administered at 03:04 a.m. 42. On 5/22/2022, the 04:00 p.m. dose was documented as administered at 09:46 p.m. 43. On 5/22/2022, the 08:00 p.m. dose was documented as administered at 09:49 p.m. 44. On 5/23/2022, the 12:00 a.m. dose was documented as administered at 02:01 a.m. 45. On 5/23/2022, the 04:00 p.m. dose was documented as administered at 05:04 p.m. 46. On 5/24/2022, the 12:00 a.m. dose was documented as administered at 06:27 a.m. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	47. On 5/24/2022, the 04:00 a.m. dose was documented as administered at 06:27 a.m. 48. On 5/25/2022, the 12:00 a.m. dose was documented as administered at 06:25 a.m. 49. On 5/25/2022, the 04:00 a.m. dose was documented as administered at 06:25 a.m. 50. On 5/26/2022, the 12:00 a.m. dose was documented as administered at 07:24 a.m. 51. On 5/26/2022, the 04:00 a.m. dose was documented as administered at 06:40 a.m. 52. On 5/26/2022, the 04:00 p.m. dose was documented as administered at 05:23 p.m. 53. On 5/27/2022, the 12:00 a.m. dose was documented as administered at 06:36 a.m. 54. On 5/27/2022, the 08:00 p.m. dose was documented as administered at 09:21 p.m. 55. On 5/28/2022, the 12:00 a.m. dose was documented as administered at 05:49 a.m. 56. On 5/29/2022, the 04:00 p.m. dose was documented as administered at 06:56 p.m. 57. On 5/29/2022, the 08:00 p.m. dose was documented as administered at 10:07 p.m. 58. On 5/30/2022, the 12:00 a.m. dose was documented as administered at 03:39 a.m. 59. On 5/30/2022, the 04:00 p.m. dose was documented as administered at 07:36 p.m. 60. On 5/30/2022, the 08:00 p.m. dose was documented as administered at 10:01 p.m. 61. On 5/31/2022, the 12:00 a.m. dose was documented as administered at 06:44 a.m. 62. On 5/31/2022, the 04:00 a.m. dose was documented as administered at 06:44 a.m. 63. On 6/03/2022, the 04:00 a.m. dose was documented as administered at 06:08 a.m. 64. On 6/04/2022, the 12:00 a.m. dose was documented as administered at 06:35 a.m. 65. On 6/04/2022, the 04:00 a.m. dose was documented as administered at 06:35 a.m. 66. On 6/04/2022, the 04:00 p.m. dose was documented as administered at 05:05 p.m. 67. On 6/05/2022, the 12:00 a.m. dose was documented as administered at 06:25 a.m. 68. On 6/05/2022, the 04:00 p.m. dose was documented as administered at 06:52 p.m. 69. On 6/06/2022, the 04:00 p.m. dose was documented as administered at 05:11 p.m. 70. On 6/06/2022, the 08:00 p.m. dose was documented as administered on 6/07/2022 at 01:12 a.m. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	71. On 6/08/2022, the 04:00 p.m. dose was documented as administered on 6/09/2022 at 01:20 a.m. 72. On 6/08/2022, the 08:00 p.m. dose was documented as administered on 6/09/2022 at 01:21 a.m. 73. On 6/09/2022, the 08:00 p.m. dose was documented as administered on 6/10/2022 at 12:35 a.m. 74. On 6/10/2022, the 08:00 p.m. dose was documented as administered at 09:24 p.m. 75. On 6/11/2022, the 04:00 a.m. dose was documented as administered at 06:14 a.m. 76. On 6/13/2022, the 04:00 a.m. dose was documented as administered at 05:46 a.m. 77. On 6/14/2022, the 04:00 a.m. dose was documented as administered at 05:16 a.m. 78. On 6/15/2022, the 08:00 p.m. dose was documented as administered at 09:26 p.m. 79. On 6/16/2022, the 08:00 p.m. dose was documented as administered at 09:57 p.m. 80. On 6/17/2022, the 12:00 a.m. dose was documented as administered at 01:26 a.m. A review of Resident 1 ' s MAR for 5/2022 and 6/2022 Administration Details indicated the Morphine ER 90mg medication scheduled time and the actual time it was removed and signed as being given as follows: 1. On 5/06/2022, the 09:00 p.m. dose was documented as administered at 10:40 p.m. 2. On 5/09/2022, the 09:00 p.m. dose was documented as administered on 5/10/2022 at 05:20 a.m. 3. On 5/15/2022, the 09:00 p.m. dose was documented as administered at 11:00 p.m. 4. On 5/17/2022, the 09:00 a.m. dose was documented as administered at 11:40 a.m. 5. On 5/24/2022, the 09:00 a.m. dose was documented as administered at 10:36 a.m. 6. On 5/26/2022, the 09:00 p.m. dose was documented as administered at 10:44 p.m. 7. On 5/29/2022, the 09:00 p.m. dose was documented as administered at 10:08 p.m. 8. On 6/02/2022, the 09:00 p.m. dose was documented as administered at 11:14 p.m. 9. On 6/06/2022, the 09:00 p.m. dose was documented as administered on 6/7/2022 at 01:11 a.m. 10. On 6/08/2022, the 09:00 p.m. dose was documented as administered on 6/9/2022 at 01:24 a.m. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	During an interview and record review on 6/16/2022 at 4:11 p.m. with Licensed Vocational Nurse 4 (LVN 4), Resident 1 ' s 05/2022 and 06/2022 MAR was reviewed. LVN 4 reported that the facility policy is that medications should be given one hour before or one hour after the scheduled administration time. LVN 4 stated she gives routine pain medications to Resident 1 twice during her of 11:00 p.m. to 7:00 a.m. shift. LVN 4 stated Resident 1 has screamed at her and demanded his pain medications be given whenever LVN 4 is more than an hour late in giving the resident his pain medications. LVN 4 stated that every time she administers Resident 1 ' s pain medication one hour outside of the scheduled time, it is a late medication administration, and she is not following facility policy. During an interview and concurrent record review on 7/7/2022 at 03:10 p.m. with Registered Nurse 1 (RN 1), Resident 1 ' s MAR for 5/2022, 6/2022 and Skilled Nursing Facility ' s (SNF) Medical Records were reviewed. RN 1 stated that Resident 1 had informed her that his scheduled pain medications, particularly his Oxycodone scheduled for 4:00 a.m. is always administered late. RN 1 stated that Resident 1 complains of excruciating pain whenever his pain medications are given late. RN 1 stated she has been advising the other licensed nurses to give Resident 1 ' s scheduled pain medications timely. RN 1 stated that after reviewing Resident 1 ' s MAR for 5/2022 and 5/2022, the physician ' s orders for Oxycodone and Morphine were not followed as the medications were not given timely. RN 1 stated that the plan for Resident 1 is to administer pain medications as per the physician ' s orders and to also evaluate the effectiveness of the pain medication after administration. RN 1 reviewed Resident 1 ' s SNF Medical Records and stated that there was no documented evidence that Resident 1 ' s pain was reassessed after being given pain medications. RN 1 stated that it is important to do a post assessment after pain medication is given to know if the pain medication was effective and that Resident 1 ' s pain has been alleviated. RN 1 stated that she has seen Resident 1 get mad and scream multiple times at the licensed nurses and staff when his pain medications were being given late. RN 1 stated that Resident 1 is continent (able to control) his bowel and bladder. RN 1 stated that he does recall instances where in Resident 1 required assistance with cleaning because he defecated on himself but was unable to recall the exact dates. During an interview and record review on 6/17/2022 at 12:01 p.m. with the Director of Nursing 1 (DON 1), Resident 1 ' s MAR for 05/2022 and 06/2022 was reviewed. DON 1 stated that each time a licensed nurse administered a medication outside of the one-hour window for the scheduled time, it is considered a late medication administration. DON 1 reviewed Resident 1 ' s MAR for 05/2022 and 06/2022 and stated that there was a total of 80 instances where in Resident 1 did not receive his Oxycodone on schedule as prescribed by the physician, and 10 instances where in Resident 1 did not receive his Morphine on schedule as prescribed by the physician. During an interview and record review on 7/7/2022 at 05:30 p.m. with the Director of Nursing 2 (DON 2), Resident 1 ' s MAR for 05/2022 and 06/2022 was reviewed. DON 2 stated that each and every time a licensed nurse administered a medication outside of the one-hour window for the scheduled time, it is considered a late medication administration. DON 2 reviewed Resident 1 ' s MAR for 05/2022 and 06/2022 and stated that there was a total of 80 instances where in Resident 1 did not receive his Oxycodone on schedule as prescribed by the physician, and 10 instances where in Resident 1 did not receive his Morphine on schedule as prescribed by the physician. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	During an interview and record review on 7/06/2022 at 06:15 p.m. with DON 2, Resident 1 ' s care plan titled, Acute/Chronic Pain revised 6/17/2022 was reviewed. DON 2 stated that the facility policies were not followed as the licensed nurses did not administer pain medication as per physician ' s orders and did not assess pain after an analgesic is given to determine effectiveness of the analgesic. B. A review of Resident 2 ' s Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included paraplegia (loss of movement and sensation in both legs, sometimes, part of the lower abdomen) and dorsalgia (physical discomfort occurring anywhere on the spine or back, ranging from mild to disabling). A review of Resident 2 ' s History and Physical dated 12/26/2021, indicated that the resident had the capacity to understand and make decisions. A review of Resident 2 ' s MDS, dated [DATE], indicated Resident 2 is cognitively intact with skills required for daily decision making. Resident 2 was totally dependence on staff with Activities of Daily Living and required one-person extensive assistance (resident involved in activity, staff provide weight-bearing support) with dressing, toilet use, and personal hygiene. A review of Resident 2's Physicians Order, dated 12/24/2021, indicated an order to administer Hydrocodone-Acetaminophen (Norco - a medication used to relieve pain) 5/325 mg by mouth three times a day for pain management with administration times at 9:00 a.m., at 5:00 p.m., and at 1:00 a.m. A review of Resident 2 ' s Care Plan titled, Pain, dated 4/12/2022 and revised on 6/03/2022, indicated Resident 2 will be free of any discomfort or adverse side effects from receiving pain medication. Interventions indicated were to administer analgesia (Hydrocodone-Acetaminophen 5-325mg) as per physician ' s order and evaluate the effectiveness of pain interventions. During a concurrent observation and interview on 6/3/2022 at 12:36 p.m., observed Resident 2 sitting on her bed in a high [NAME] ' s position (sitting upright with the spine straight), awake and watching television. Resident 2 stated she is paralyzed from her sternum (breastbone) to her legs, but experiences constant pain. Resident 2 stated that her scheduled pain medication of Norco has been administered to her more than an hour late on multiple occasions. Resident 2 stated it will help her more if the nurses give her pain medications on time to help make her pain more tolerable. A review of Resident 2 ' s MAR Details for 5/2022 and 6/2022 indicated that Resident 2 ' s order for Hydrocodone- Acetaminophen 5/325 mg was not followed as per the physician ' s order by: 1. On 5/01/2022, the 01:00 a.m. dose was documented as administered at 05:13 a.m. 2. On 5/02/2022, the 05:00 p.m. dose was documented as administered 5/03/2022 at 01:03 a.m. 3. On 5/03/2022, the 01:00 a.m. dose was documented as administered at 06:25 a.m. 4. On 5/03/2022, the 09:00 a.m. dose was documented as administered at 10:58 a.m. 5. On 5/03/2022, the 05:00 p.m. dose was documented as administered at 08:43 p.m. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	6. On 5/04/2022, the 01:00 a.m. dose was documented as administered at 06:22 a.m. 7. On 5/05/2022, the 01:00 a.m. dose was documented as administered at 06:03 a.m. 8. On 5/06/2022, the 01:00 a.m. dose was documented as administered at 06:19 a.m. 9. On 5/06/2022, the 09:00 a.m. dose was documented as administered at 10:36 a.m. 10. On 5/06/2022, the 05:00 p.m. dose was documented as administered 5/07/2022 at 12:03 a.m. 11. On 5/07/2022, the 01:00 a.m. dose was documented as administered at 06:15 a.m. 12. On 5/07/2022, the 09:00 a.m. dose was documented as administered at 10:50 a.m. 13. On 5/07/2022, the 05:00 p.m. dose was documented as administered at 12:56 a.m. 14. On 5/08/2022, the 09:00 a.m. dose was documented as administered at 10:34 a.m. 15. On 5/09/2022, the 09:00 a.m. dose was documented as administered at 10:34 a.m. 16. On 5/09/2022, the 05:00 p.m. dose was documented as administered at 06:31 p.m. 17. On 5/10/2022, the 01:00 a.m. dose was documented as administered at 06:11 a.m. 18. On 5/10/2022, the 09:00 a.m. dose was documented as administered at 10:38 a.m. 19. On 5/10/2022, the 05:00 p.m. dose was documented as administered at 06:31 p.m. 20. On 5/12/2022, the 01:00 a.m. dose was documented as administered at 06:14 a.m. 21. On 5/12/2022, the 05:00 p.m. dose was documented as administered at 06:45 p.m. 22. On 5/13/2022, the 09:00 a.m. dose was documented as administered at 10:35 a.m. 23. On 5/15/2022, the 01:00 a.m. dose was documented as administered at 06:09 a.m. 24. On 5/16/2022, the 01:00 a.m. dose was documented as administered at 02:41 a.m. 25. On 5/16/2022, the 05:00 p.m. dose was documented as administered at 07:08 p.m. 26. On 5/17/2022, the 01:00 a.m. dose was documented as administered at 06:15 a.m. 27. On 5/17/2022, the 09:00 a.m. dose was documented as administered at 10:58 a.m. 28. On 5/17/2022, the 05:00 p.m. dose was documented as administered at 06:16 p.m. 29. On 5/18/2022, the 01:00 a.m. dose was documented as administered at 07:40 a.m. (continued on next page)

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	555738	A. Building B. Wing	07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

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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 0697 Level of Harm - Actual harm Residents Affected - Some	30. On 5/19/2022, the 01:00 a.m. dose was documented as administered at 06:39 a.m. 31. On 6/01/2022, the 01:00 a.m. dose was documented as administered at 06:04 a.m. 32. On 6/02/2022, the 01:00 a.m. dose was documented as administered at 05:57 a.m. 33. On 6/03/2022, the 01:00 a.m. dose was documented as administered at 06:19 a.m. 34. On 6/03/2022, the 05:00 p.m. dose was documented as administered at 10:59 p.m. 35. On 6/04/2022, the 01:00 a.m. dose was documented as administered at 06:11 a.m. 36. On 6/05/2022, the 01:00 a.m. dose was documented as administered at 03:13 a.m. 37. On 6/05/2022, the 05:00 p.m. dose was documented as administered at 09:19 p.m. 38. On 6/06/2022, the 01:00 a.m. dose was documented as administered at 04:10 a.m. During an interview and concurrent record review on 7/6/2022 at 01:18 p.m. with Licensed Vocational Nurse 1, Resident 2 ' s MAR for 05/2022, 06/2022, and Resident 2 ' s SNF medical records was reviewed. LVN 1 stated that she provides pain medication to Resident 2 during her shift of 7:00 a.m. to 3:00 p.m. LVN 1 stated after reviewing Resident 1 ' s MAR for 5/2022 and 6/2022 that there was a total of 38 entries that indicated Resident 2 received his scheduled Norco pain medications late. LVN 1 stated that after reviewing Resident 2 ' s MAR dated 5/2022 and 6/2022, she administered the resident ' s Norco late a total of 12 times. LVN 1 reported that she did not follow the facility policy and procedure that medications should be given within one hour before or one hour after the scheduled administration time. LVN 1 reviewed Resident 2 ' s SNF medical records and stated that there was no documented evidence that a post pain assessment was done after the resident had been given pain medications. LVN 1stated that they did not follow Resident ' s 2 care plan titled, Pain dated 4/12/2022, which indicated to assess pain after administering analgesic. LVN 1 stated there should be a post pain assessment for routine medications to evaluate the effectiveness of the analgesic. During a concurrent interview and record review on 7/6/2022 at 07:10 p.m. with DON 2, Resident 2 ' s MAR for 05/2022 and 06/2022 were reviewed. DON 2 stated that there was a total of 38 instances where Resident 2 received their scheduled Norco late. DON 2 stated that licensed nurses did not follow the care plan to administer analgesics as scheduled as per physician orders. During a concurrent interview and record review on 7/6/2022 at 07:25 p.m. with DON 2, Resident 2 ' s care plan titled, Pain dated 4/12/2022 was reviewed. DON 2 stated that licensed nurses did not follow the care plan to document post pain assessment after each pain medication given to determine effectiveness of the analgesic. C. A review of Resident 3 ' s Face Sheet indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anxiety (feelings of uneasiness) and depression (feelings of sadness). (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	A review of Resident 3 ' s MDS, dated [DATE], indicated Resident 3 had intact cognition with skills required for daily decision making. The MDS further indicated that Resident 3 required one-person extensive assistance (resident involved in activity, staff provide weight-bearing support) with dressing, toilet use, and personal hygiene. A review of Resident 3 ' s Physician ' s Orders indicated the following: 1. Methadone (medication to treat pain) Solution 10 mg/5 milliliters (ml, a unit of measure)- give 7.5 mg. by mouth three times a day for polyneuropathy (damage to many nerves that can cause pain and loss of sensation), dated 4/17/2022. 2. Methadone Solution 5 mg/5 ml- give 7.5 mg. by mouth three times a day for polyneuropathy, dated 3/08/2022. During an interview with Resident 3 on 6/17/2022 at 10:25 a.m., Resident 3 stated that when she receives her prescribed methadone late, the pain doubles and takes longer to bring the pain under control, which then makes it difficult to move. Resident 3 stated she has cried several times due to the pain. Resident 3 stated, many times she does not receive her pain medications on time and is often left waiting for over an hour. Resident 3 stated Licensed Vocational Nurse 5 (LVN 5) is one of the nurses that often gives her prescribed dose of methadone late. A review of Resident 3 ' s Care Plan titled, Acute Pain, initiated 6/16/2022, indicated a goal that Resident 3 will be free from pain/discomfort. One of the interventions indicated was to administer pain medications per physician ' s order. A review of Resident 3 ' s MAR Details for 5/2022 and 6/2022 indicated that Resident 3 ' s order for Methadone 7.5 mg. was not followed as per the physician ' s order by: 1. On 5/02/2022, the 8:00 p.m. dose was documented as administered at 9:40 p.m. 2. On 5/04/2022, the 1:00 p.m. dose was documented as administered at 2:18 p.m. 3. On 5/10/2022, the 8:00 p.m. dose was documented as administered on 5/11/2022 at 12:06 a.m. 4. On 5/13/2022, the 8:00 p.m. dose was documented as administered at 11:50 p.m. 5. On 5/16/2022, the 8:00 p.m. dose was documented as administered at 10:43 p.m. 6. On 5/17/2022, the 8:00 p.m. dose was documented as administered at 9:20 p.m. 7. On 5/18/2022, the 8:00 p.m. dose was documented as administered at 9:27 p.m. 8. On 5/24/2022, the 8:00 p.m. dose was documented as administered at 11:05 p.m. 9. On 5/28/2022, the 8:00 p.m. dose was documented as administered at 9:17 p.m. 10. On 5/31/2022, the 8:00 p.m. dose was documented as administered at 11:04 p.m. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	11. On 6/03/2022, the 8:00 p.m. dose was documented as administered at 9:55 p.m. 12. On 6/07/2022, the 8:00 p.m. dose was documented as administered on 6/08/2022 at 12:01 a.m. 13. On 6/14/2022, the 8:00 p.m. dose was documented as administered on 6/15/2022 at 12:49 a.m. 14. On 6/21/2022, the 8:00 p.m. dose was documented as administered at 9:42 p.m. During a concurrent interview and record review on 7/07/2022 at 4:00 p.m. with LVN 5, Resident 3 ' s MAR for 5/2022 and 6/2022 was reviewed. LVN 5 stated that after reviewing Resident 3 ' s MAR for 5/2022 and 6/2022, there were a total of nine instances where she documented one hours past the scheduled time of administering Resident 3 ' s methadone. LVN 5 stated that the late administrations on the MAR were due to having computer documentation issues. When asked to provide any other documented evidence that the medications were given timely as the MAR indicated that LVN 5 administered methadone late on nine instance, LVN 5 was not able to explain nor show additional evidence to show that the medications were administered as scheduled. During an interview with the Assistant Director of Nurses (ADON) on 6/06/2022 at 12:55 pm., ADON stated that pain medications are to be given on time, either one hour before the scheduled time or one hour after the scheduled time. The ADON stated if a pain medication is given late, then a resident can have increased pain that is difficult to control. During a concurrent interview and record review on 7/06/2022 at 4:18 p.m. with DON 2, Resident 3 ' s MAR for 5/2022 and 6/2022 was reviewed. The DON stated that the MAR indicated that Resident 3 received 14 doses of Methadone late. A review of the facility ' s policy and procedure titled, Pain Management, reviewed 2/16/2022, indicated the facility is to manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the patient ' s goals and preferences. The policy also indicated a plan of care is developed for residents, documented, and updated as needed. Pain is assessed at least every shift, when a patient complains of pain and after an analgesic is given to determine effectiveness of the analgesic. A review of the facility's policy and procedure titled, Medication Administration- General Guidelines, dated 4/2008, indicated that Medications are administered in accordance with written orders of the attending physician, medications are administered within 60 minutes of scheduled time (one hour before and one hour after). A review of the facility's policy and procedure titled, Pain Assessment and Management, reviewed 2/16/2022, indicated the facility recognizes the patients right to be free of pain and promotes pain free relief through the use of pain management plan during the patient duration of stay at the facility to help the patient obtain or maintain his or her highest practicable level of well-being and to prevent or manage pain to the extent possible.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45579 Based on observation, interview, and record review, the facility: 1. Failed to ensure that licensed nurses signed the Medication Administration Record (MAR, the report that serves as a legal record of the drugs administered to a resident by licensed nursing staff) after administering a control substance (medications with a high potential for abuse) for four of six sampled residents (Resident 1, Resident 2, Resident 4, and Resident 5). 2. Failed to ensure that licensed nurses signed the Control Drug Record (a log signed by licensed nurse with date and time a controlled substance is given to a resident) after administering a control substance medication for two of six sampled resident (Resident 2 and Resident 4). 3. Failed to ensure that licensed nurses signed both the MAR and the Control Drug Record for two of six sampled residents (Resident 2 and Resident 4) after administering a control substance medication. These deficient practices had the potential to result in confusion in the care and services provided to the residents, drug loss, drug diversion (transfer of a medication from a legal to an illegal use), or accidental exposure to controlled substances. Findings: A. A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic gout (a form of arthritis [joint inflammation] characterized by severe pain, redness, and tenderness in joints.) and diabetic mellitus (the body ' s inability to control sugar in the blood). A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/1/2022, indicated Resident 1 is cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. A review of Resident 1 ' s Physician ' s Order, indicated an order for Oxycodone Hydrochloride (Oxycodone HCL- medication to treat pain) 30 milligrams (mg- a unit of measure), give two tablets by mouth every four hours for severe pain, hold of respiratory rate (RR -normal range of breaths are from 12 to 20 respirations per minute) below 12 or sedated, order start date of 11/25/2021. A review of the Resident 1's Oxycodone 30 mg Controlled Drug Record indicated the removal of three doses on the following dates: 1. On 5/21/2022 at 4:00 a.m. 2. On 6/3/2022 at 4:00 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 6/3/2022 at 8:00 p.m. However, a review Resident 1 ' s 5/2022 and 6/2022 MAR did not have documentation that corresponded with the removal of the three doses of Oxycodone 30mg for Resident 1. During a concurrent interview and record review on 6/6/2022 at 1:30 p.m. with the Assistant Director of Nursing (ADON), Resident 1 ' s Controlled drug record for Oxycodone 30mg and Resident 1 ' s MAR for 5/2022 and 6/2022 were reviewed. ADON stated and confirmed that there were three instances where in the licensed nurse documented the removal of Oxycodone in Resident 1 ' s Control Drug Record, but did not document the medication as administered in Resident 1 ' s MAR. The ADON stated that this was a discrepancy. ADON stated that controlled drug record and MAR should be documented immediately after the medication is administered to a resident. B. A review of Resident 2 ' s Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included paraplegia (loss of movement and sensation in both legs, sometimes, part of the lower abdomen) and dorsalgia (physical discomfort occurring anywhere on the spine or back, ranging from mild to disabling). A review of Resident 2 ' s MDS, dated [DATE], indicated Resident 2 is cognitively intact with skills required for daily decision making. Resident 2 was totally dependence on staff with Activities of Daily Living and required one-person extensive assistance (resident involved in activity, staff provide weight-bearing support) with dressing, toilet use, and personal hygiene. A review of Resident 2's Physicians Order, dated 12/24/2021, indicated an order to administer Hydrocodone-Acetaminophen (Norco - a medication used to relieve pain) 5/325 mg by mouth three times a day for pain management with administration times at 9:00 a.m., at 5:00 p.m., and at 1:00 a.m. A review of the Resident 2's Hydrocodone- Acetaminophen 5/325 mg Controlled Drug Record indicated two doses had been removed on the following dates: 1. On 5/20/22 at 5:00 p.m. 2. On 6/04/22 at 5:00 p.m. However, a review Resident 2 ' s 5/2022 and 6/2022 MAR did not have documentation that corresponded with the removal of the two doses of Hydrocodone- Acetaminophen 5/325 mg for Resident 2. During a concurrent interview and record review on 7/6/2022 at 7:10 p.m. with the Director of Nursing 2 (DON 2), Resident 2 ' s Hydrocodone- Acetaminophen 5/325mg Controlled Drug Record and MAR for 5/2022 and 6/2022 were reviewed. DON 2 confirmed that licensed nurses did not document on the Hydrocodone- Acetaminophen 5/325 mg MAR after signing the controlled drug record for Resident 2 ' s Hydrocodone- Acetaminophen medication. DON 2 stated that the facility did not follow the policy regarding administering controlled records and that licensed nurses should have signed the MAR when administering controlled medications to a resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. A review of Resident 4 ' s Face Sheet indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included Dementia (loss of cognitive functioning - thinking, remembering, and reasoning) and Heart Failure (condition in which the heart muscle is unable to pump enough blood to meet the body ' s needs for blood and oxygen). A review of Resident 4 ' s MDS, dated [DATE], indicated Resident 4 is not cognitively intact with skills required for daily decision making and requires extensive assistance during bed mobility, transfers, dressing, toilet use and personal hygiene with one-to-two or more-person physical assistance. A review of Resident 4's Physicians Order, dated 12/24/2021, indicated an order to administer Hydrocodone-Acetaminophen 10/325 mg by mouth every six hours for pain management. A review of the Resident 4's Hydrocodone- Acetaminophen 10/325mg Controlled Drug Record indicated four doses had been removed on the following dates: 1. On 5/8/2022 at 6:00 a.m. 2. On 5/15/2022 at 6:00 a.m. 3. On 6/03/2022 at 6:00 p.m. 4. On 6/04/2022 at 6:00 p.m. However, a review Resident 4 ' s 5/2022 and 6/2022 MAR did not have documentation that corresponded with the removal of the four doses of Hydrocodone- Acetaminophen 10/325 mg for Resident 4. During a concurrent interview and record review on 7/6/2022 at 07:02 p.m. with the DON 2, Resident 4 ' s Hydrocodone- Acetaminophen 10/325 mg Control Drug Record and 5/2022 and 6/2022 MAR were reviewed. DON 2 confirmed that licensed nurses did not document on the MAR after signing the controlled drug record for Resident 2 ' s Hydrocodone- Acetaminophen medication. DON 2 stated that the facility did not follow the policy regarding administering controlled records and that licensed nurses should have signed the MAR when administering controlled medications to a resident. D. A review of Resident 5 ' s Face Sheet indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included low back pain (physical discomfort occurring anywhere on the spine or back) and discitis (an infection in the spinal cord). A review of Resident 5 ' s MDS, dated [DATE], indicated Resident 5 is cognitively intact with skills required for daily decision making, requires limited assistance during bed mobility, transfers, dressing, toilet use and personal hygiene with one-person physical assistance. A review of Resident 5's Physicians Order dated 4/04/2022, indicated an order to administer Methadone Hydrochloride (Methadone-medication to treat pain) tablet 10 mg by mouth every 12, and notify Medical Doctor (MD) if respiratory rate is below 12. A review of the Resident 5's Methadone Hydrochloride 10mg Controlled Drug Record indicated four doses had been removed on the following dates: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 5/9/22 at 9:00 p.m. 2. On 5/20/22 at 9:00 p.m. 3. On 6/1/222 at 9:00 p.m. 4. On 6/4/222 at 9:00 p.m. A review of Resident 5 ' s 5/2022 and 6/2022 MAR did not have documentation that corresponded with the removal of the four doses of Methadone Hydrochloride 10mg. During a concurrent interview and record review on 7/6/2022 at 4:10 p.m. with the Director of Nursing 2 (DON 2), Resident 5 ' s Methadone Hydrochloride 10mg Control Drug Record and 05/2022 and 06/2022 MAR were reviewed. DON 2 stated that licensed nurses did not document on Resident 5 ' s 5/2022 and 6/2022 MAR for Methadone 10 mg after signing the controlled drug record for the four doses. DON 2 stated that the facility did not follow the policy regarding administering controlled records and that licensed nurses should have signed the MAR when administering controlled medications to a resident. A review of the facility's policy dated 8/2014, reviewed 2/16/2022, titled Preparation and General Guidelines-Controlled Medications, the policy indicated that when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR); date and time of administration, amount administered, signature of the nurse administering the dose on the accountability record at the time of the medication is removed from the supply, and initials of the nurse administering the dose on the MAR after the medication is administered. E. A review of the Resident 2's 5/2022 and 6/2022 MAR for Hydrocodone- Acetaminophen 5/325 mg indicated seven doses had been administered as followed: 1. On 5/01/22 at 1:00 a.m. 2. On 5/03/22 at 9:00 a.m. 3. On 5/07/22 at 5:00 p.m. 4. On 5/09/22 at 1:00 a.m. 5. On 5/16/22 at 1:00 a.m. 6. On 5/17/22 at 5:00 p.m. 7. On 6/05/22 at 5:00 p.m. However, a review of Resident 2 ' s Hydrocodone- Acetaminophen 5/325mg Controlled Drug Record did not indicate signatures from the licensed nurses that medication was removed from the medication card (bubble pack) on the corresponding dates and times as indicated in the MAR. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/6/2022 at 7:15 p.m. with the DON 2, Resident 2 ' s Hydrocodone- Acetaminophen Controlled drug record and MAR for 05/2022 and 06/2022 were reviewed. DON 2 stated that licensed nurses did not document on Resident 2 ' s Hydrocodone- Acetaminophen 5/325 mg controlled drug record after removing and administering seven doses of the medication as indicated in the residents MAR. F. A review of the Resident 4's 5/2022 and 6/2022 MAR indicated 13 doses of Hydrocodone- Acetaminophen 10/325mg had been administered as followed: 1. On 5/14/22 at 6:00 p.m. 2. On 5/16/22 at 12:00 a.m. 3. On 5/16/22 at 6:00 a.m. 4. On 5/18/22 at 12:00 p.m. 5. On 5/21/22 at 6:00 p.m. 6. On 5/22/22 at 6:00 p.m. 7. On 5/23/22 at 12:00 a.m. 8. On 5/23/22 at 6:00 a.m. 9. On 5/25/22 at 12:00 p.m. 10. On 5/29/22 at 12:00 p.m. 11. On 5/30/22 at 12:00 a.m. 12. On 6/04/22 at 12:00 p.m. 13. On 6/05/22 at 6:00 a.m. However, a review of Resident 4 ' s Hydrocodone- Acetaminophen 10/325mg Controlled Drug Records did not indicate signatures from the licensed nurses that medication was removed was removed from the medication card (bubble pack) on the corresponding dates and times as indicated in the MAR. During a concurrent interview and record on 7/6/2022 at 07:02 p.m. DON 2, Resident 4 ' s Hydrocodone-Acetaminophen Controlled 10/325 mg controlled drug record and MAR for 05/2022 and 06/2022 were reviewed. DON 2 stated that licensed nurses did not sign the controlled drug record for Resident 2 ' s Hydrocodone- Acetaminophen 10/325mg after removing and administering 13 doses of the medication as indicated in the residents MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy dated 8/2014, reviewed 2/16/2022, titled Preparation and General Guidelines-Controlled Medications, the policy indicated that when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR); date and time of administration, amount administered, signature of the nurse administering the dose on the accountability record at the time of the medication is removed from the supply, and initials of the nurse administering the dose on the MAR after the medication is administered. G. A review of the Resident 2's Hydrocodone- Acetaminophen 5/325mg Controlled Drug Record and MAR for 5/2022 indicated five doses were not documented on the following dates and times as scheduled per physician ' s order: 1. On 5/8/22 at 1:00 a.m. 2. On 5/9/22 at 5:00 p.m. 3. On 5/15/22 at 1:00 a.m. 4. On 5/20/22 at 5:00 p.m. 5. On 5/28/22 at 9:00 a.m. During a concurrent interview and record review on 7/6/2022 at 7:15 p.m. with the DON 2, Resident 2 ' s Hydrocodone- Acetaminophen 5/325mg Controlled Drug Record and MAR for 5/2022 were reviewed. DON 2 stated that licensed nurses did not document on Resident 2 ' s MAR and controlled drug record for the scheduled Hydrocodone- Acetaminophen 5/325mg medication. DON 2 stated that the licensed nurses did not follow the facility policies regarding administering controlled medications by immediately recording on the controlled drug record and the MAR whenever a controlled medication is administered H. A review of the Resident 4's Hydrocodone- Acetaminophen 10/325mg Controlled Drug Record and MAR for 5/2022 indicated five doses were not documented on the following dates and times as scheduled per physician ' s order: 1. On 5/8/22 at 12:00 a.m. 2. On 5/9/22 at 06:00 p.m. 3. On 5/15/22 at 12:00 a.m. 4. On 5/20/22 at 06:00 a.m. 5. On 5/20/22 at 06:00 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555738	A. Building B. Wing	07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/6/2022 at 06:54 p.m. with the DON 2, Resident 4 ' s Hydrocodone- Acetaminophen 10/325mg Controlled Drug Record and MAR for 5/2022 were reviewed. DON 2 stated that licensed nurses did not document on Resident 4 ' s MAR and controlled drug record for the scheduled Hydrocodone- Acetaminophen 10/325mg medication. DON 2 stated that the licensed nurses did not follow the facility policies regarding administering controlled medications by immediately recording on the controlled drug record and the MAR whenever a controlled medication is administered. A review of the facility's policy dated 4/2008, reviewed 2/16/2022, titled Medication Administration-General Guidelines, the policy indicated that medications are administered in accordance with written orders of the attending physician. The individual who administers the medication dose records the administration on the resident ' s MAR directly after the medication is given. A review of the facility's policy dated 8/2014, reviewed 2/16/2022, titled Preparation and General Guidelines-Controlled Medications, the policy indicated that when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR); date and time of administration, amount administered, signature of the nurse administering the dose on the accountability record at the time of the medication is removed from the supply, and initials of the nurse administering the dose on the MAR after the medication is administered.

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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 0760 Level of Harm - Actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45579 Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors for four of six sampled residents (Resident 1, Resident 2, Resident 3, and Resident 5) when the facility failed to: 1. Administer 80 doses as scheduled per the physician ' s order of Oxycodone Hydrochloride (Oxycodone HCL- medication to treat pain) 60 milligrams (mg-unit of measure) to Resident 1 between 5/1/2022 and 6/30/2022. 2. Administer 10 doses of Morphine Sulfate (medication to treat pain) 90 mg as scheduled per the physician ' s order to Resident 1 between 5/1/2022 and 6/30/2022. 3. Administer 38 doses of Hydrocodone- Acetaminophen (Norco-medication use to treat pain) 5/325 mg as scheduled per the physician ' s order to Resident 2 between 5/1/2022 and 6/30/2022. 4. Administer 14 doses of Methadone (medication use to treat pain) 7.5 mg as scheduled per the physician ' s order to Resident 3 between 5/1/2022 and 6/30/2022. 5. Administer the correct prescribed dose of Norco 5/325 mg to Resident 5 between 3/4/2022 and 4/3/2022. Resident 5 was instead given 55 incorrect higher doses of Norco. The deficient practice of failing to administer medications in accordance with physician's orders caused Resident 1, Resident 2, and Resident 3 to experience severe untreated pain (pain rated at seven [7] or higher out of 10, on a pain scale from zero to ten where ten is the worst possible pain) between 5/1//2022 and 6/30/2022; and placed Resident 5 at risk of serious health complications as a result of being administered a higher dose of Norco than prescribed. Findings: A. A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic gout (a form of arthritis [joint inflammation] characterized by severe pain, redness, and tenderness in joints.) and diabetic mellitus (the body ' s inability to control sugar in the blood). A review of Resident 1 ' s History and Physical (H & P), dated 11/25/2021, indicated Resident 1 had the capacity to understand and make decisions. The History and Physical indicated Resident 1 had diagnoses that included osteoarthritis (when the protective cartilage that cushions the ends of the bones wears down over time resulting in pain) and chronic pain syndrome (pain that lasts from weeks to years). A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/1/2022, indicated Resident 1 is cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated that Resident 1 required staff assistance with setting up for toilet use. (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 0760 Level of Harm - Actual harm Residents Affected - Some	A review of Resident 1 ' s Physician ' s Order, indicated the following orders 1. Oxycodone Hydrochloride (Oxycodone HCL- medication to treat pain) 30 milligrams (mg- a unit of measure), give two tablets by mouth every four hours for severe pain, hold if respiratory rate (RR -normal range of breaths are from 12 to 20 respirations per minute) below 12 or sedated, order start date of 11/25/2021. 2. Morphine Sulfate (medication used to treat pain) Extended Release (ER, the pill is made so that the drug is released slowly over time) tablet extended release 60 mg. give one tablet by mouth every 12 hours related to chronic gout, give with 30 mg. to equal 90 mg., hold medication and notify Medical Doctor (MD) if RR is below 12, order start date of 5/04/2022. 3. Morphine Sulfate ER tablet extended release 30 mg., give one tablet by mouth every 12 hours related to chronic gout, give with 60 mg. to equal 90 mg. hold medication and notify MD if RR is below 12, order start date of 5/4/2022 A review of Resident 1 ' s Care Plan titled, Acute/Chronic Pain, dated 3/08/2022 and revised 6/17/2022, indicated Resident 1 will verbalize adequate relief of pain or resident will not have an interruption in normal activities due to pain. Interventions indicated were to administer analgesia (pain medications) as per physician ' s orders, evaluate the effectiveness of pain interventions and review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. During a concurrent observation and interview on 6/16/2022 at 12:54 p.m., observed Resident 1 sitting on his bed in his room grimacing (twisting of the facial features into an unpleasant expression) while moving. Resident 1 reported his pain was 8/10 during the interview and stated that he had just received his ordered pain medication. Resident 1 stated that since his admission into the facility, there have been multiple instances where in the licensed nurses provide his scheduled pain medication late. Resident 1 stated that on 6/16/2022, he was supposed to receive a dose of Oxycodone HCl 60 mg at 4:00 a.m., but the nurses did not administer the medication until almost 6:00 a.m. Resident 1 stated that because of the delay in receiving his pain medications timely, he was left in excruciating pain that morning. Resident 1 stated that the pain would be so excruciating that he is not able to conduct activities of daily living. Resident 1 stated that there were even episodes where he was in so much pain that he defecated (bowel movement) on himself. Resident 1 stated that this upset him because he has control of his bowel movements. During an interview on 6/17/2022 at 3:10 p.m. with Resident 1, Resident 1 stated that his scheduled 4:00 a. m. scheduled pain medications were always given past the scheduled time. Resident 1 stated he has received the medications after 5:00 a.m. on multiple occasions. Resident 1 stated he told the Licensed Nurses and Director of Nurses (DON) and that he just wants to receive his pain medications on time so that he will not suffer in pain. A review of Resident 1 ' s Medication Administration Record (MAR) Details for 5/2022 and 6/2022 indicated that Resident 1 ' s order for Oxycodone HCL 60 mg was not followed as per the physician ' s order as evidenced by being administered outside of the scheduled time: 1. On 5/03/2022, the 12:00 a.m. dose was documented as administered at 06:34 a.m. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	2. On 5/03/2022, the 04:00 a.m. dose was documented as administered at 06:34 a.m. 3. On 5/03/2022, the 08:00 a.m. dose was documented as administered at 09:12 a.m. 4. On 5/04/2022, the 12:00 a.m. dose was documented as administered at 06:30 a.m. 5. On 5/04/2022, the 04:00 a.m. dose was documented as administered at 06:30 a.m. 6. On 5/04/2022, the 04:00 p.m. dose was documented as administered at 05:12 p.m. 7. On 5/05/2022, the 12:00 a.m. dose was documented as administered at 05:56 a.m. 8. On 5/05/2022, the 04:00 a.m. dose was documented as administered at 05:56 a.m. 9. On 5/06/2022, the 12:00 a.m. dose was documented as administered at 06:30 a.m. 10. On 5/05/2022, the 04:00 a.m. dose was documented as administered at 06:30 a.m. 11. On 5/06/2022, the 12:00 a.m. dose was documented as administered at 06:30 a.m. 12. On 5/06/2022, the 04:00 a.m. dose was documented as administered at 06:30 a.m. 13. On 5/06/2022, the 04:00 p.m. dose was documented as administered at 05:10 p.m. 14. On 5/07/2022, the 12:00 a.m. dose was documented as administered at 06:30 a.m. 15. On 5/07/2022, the 04:00 a.m. dose was documented as administered at 06:30 a.m. 16. On 5/10/2022, the 12:00 a.m. dose was documented as administered at 06:02 a.m. 17. On 5/10/2022, the 04:00 a.m. dose was documented as administered at 06:02 a.m. 18. On 5/11/2022, the 12:00 a.m. dose was documented as administered at 06:35 a.m. 19. On 5/11/2022, the 04:00 a.m. dose was documented as administered at 06:35 a.m. 20. On 5/12/2022, the 12:00 a.m. dose was documented as administered at 06:30 a.m. 21. On 5/12/2022, the 04:00 a.m. dose was documented as administered at 06:30 a.m. 22. On 5/12/2022, the 04:00 p.m. dose was documented as administered at 05:09 p.m. 23. On 5/13/2022, the 12:00 a.m. dose was documented as administered at 05:43 a.m. 24. On 5/13/2022, the 04:00 a.m. dose was documented as administered at 05:43 a.m. 25. On 5/13/2022, the 12:00 a.m. dose was documented as administered at 05:43 a.m. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	26. On 5/13/2022, the 04:00 a.m. dose was documented as administered at 05:43 a.m. 27. On 5/15/2022, the 08:00 p.m. dose was documented as administered at 10:59 p.m. 28. On 5/16/2022, the 12:00 a.m. dose was documented as administered at 02:38 a.m. 29. On 5/17/2022, the 12:00 a.m. dose was documented as administered at 06:28 a.m. 30. On 5/17/2022, the 04:00 a.m. dose was documented as administered at 06:28 a.m. 31. On 5/17/2022, the 08:00 a.m. dose was documented as administered at 11:39 a.m. 32. On 5/18/2022, the 12:00 a.m. dose was documented as administered at 07:29 a.m. 33. On 5/18/2022, the 04:00 a.m. dose was documented as administered at 07:29 a.m. 34. On 5/19/2022, the 12:00 a.m. dose was documented as administered at 06:31 a.m. 35. On 5/19/2022, the 04:00 a.m. dose was documented as administered at 06:31 a.m. 36. On 5/20/2022, the 12:00 a.m. dose was documented as administered at 01:37 a.m. 37. On 5/20/2022, the 04:00 a.m. dose was documented as administered at 06:45 a.m. 38. On 5/20/2022, the 04:00 p.m. dose was documented as administered at 05:02 p.m. 39. On 5/21/2022, the 12:00 a.m. dose was documented as administered at 01:47 a.m. 40. On 5/21/2022, the 08:00 p.m. dose was documented as administered at 09:07 p.m. 41. On 5/22/2022, the 12:00 a.m. dose was documented as administered at 03:04 a.m. 42. On 5/22/2022, the 04:00 p.m. dose was documented as administered at 09:46 p.m. 43. On 5/22/2022, the 08:00 p.m. dose was documented as administered at 09:49 p.m. 44. On 5/23/2022, the 12:00 a.m. dose was documented as administered at 02:01 a.m. 45. On 5/23/2022, the 04:00 p.m. dose was documented as administered at 05:04 p.m. 46. On 5/24/2022, the 12:00 a.m. dose was documented as administered at 06:27 a.m. 47. On 5/24/2022, the 04:00 a.m. dose was documented as administered at 06:27 a.m. 48. On 5/25/2022, the 12:00 a.m. dose was documented as administered at 06:25 a.m. 49. On 5/25/2022, the 04:00 a.m. dose was documented as administered at 06:25 a.m. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	50. On 5/26/2022, the 12:00 a.m. dose was documented as administered at 07:24 a.m. 51. On 5/26/2022, the 04:00 a.m. dose was documented as administered at 06:40 a.m. 52. On 5/26/2022, the 04:00 p.m. dose was documented as administered at 05:23 p.m. 53. On 5/27/2022, the 12:00 a.m. dose was documented as administered at 06:36 a.m. 54. On 5/27/2022, the 08:00 p.m. dose was documented as administered at 09:21 p.m. 55. On 5/28/2022, the 12:00 a.m. dose was documented as administered at 05:49 a.m. 56. On 5/29/2022, the 04:00 p.m. dose was documented as administered at 06:56 p.m. 57. On 5/29/2022, the 08:00 p.m. dose was documented as administered at 10:07 p.m. 58. On 5/30/2022, the 12:00 a.m. dose was documented as administered at 03:39 a.m. 59. On 5/30/2022, the 04:00 p.m. dose was documented as administered at 07:36 p.m. 60. On 5/30/2022, the 08:00 p.m. dose was documented as administered at 10:01 p.m. 61. On 5/31/2022, the 12:00 a.m. dose was documented as administered at 06:44 a.m. 62. On 5/31/2022, the 04:00 a.m. dose was documented as administered at 06:44 a.m. 63. On 6/03/2022, the 04:00 a.m. dose was documented as administered at 06:08 a.m. 64. On 6/04/2022, the 12:00 a.m. dose was documented as administered at 06:35 a.m. 65. On 6/04/2022, the 04:00 a.m. dose was documented as administered at 06:35 a.m. 66. On 6/04/2022, the 04:00 p.m. dose was documented as administered at 05:05 p.m. 67. On 6/05/2022, the 12:00 a.m. dose was documented as administered at 06:25 a.m. 68. On 6/05/2022, the 04:00 p.m. dose was documented as administered at 06:52 p.m. 69. On 6/06/2022, the 04:00 p.m. dose was documented as administered at 05:11 p.m. 70. On 6/06/2022, the 08:00 p.m. dose was documented as administered on 6/07/2022 at 01:12 a.m. 71. On 6/08/2022, the 04:00 p.m. dose was documented as administered on 6/09/2022 at 01:20 a.m. 72. On 6/08/2022, the 08:00 p.m. dose was documented as administered on 6/09/2022 at 01:21 a.m. 73. On 6/09/2022, the 08:00 p.m. dose was documented as administered on 6/10/2022 at 12:35 a.m. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	74. On 6/10/2022, the 08:00 p.m. dose was documented as administered at 09:24 p.m. 75. On 6/11/2022, the 04:00 a.m. dose was documented as administered at 06:14 a.m. 76. On 6/13/2022, the 04:00 a.m. dose was documented as administered at 05:46 a.m. 77. On 6/14/2022, the 04:00 a.m. dose was documented as administered at 05:16 a.m. 78. On 6/15/2022, the 08:00 p.m. dose was documented as administered at 09:26 p.m. 79. On 6/16/2022, the 08:00 p.m. dose was documented as administered at 09:57 p.m. 80. On 6/17/2022, the 12:00 a.m. dose was documented as administered at 01:26 a.m. A review of Resident 1 ' s MAR for 5/2022 and 6/2022 Administration Details indicated the Morphine ER 90mg medication scheduled time and the actual time it was removed and signed as being given as follows: 1. On 5/06/2022, the 09:00 p.m. dose was documented as administered at 10:40 p.m. 2. On 5/09/2022, the 09:00 p.m. dose was documented as administered on 5/10/2022 at 05:20 a.m. 3. On 5/15/2022, the 09:00 p.m. dose was documented as administered at 11:00 p.m. 4. On 5/17/2022, the 09:00 a.m. dose was documented as administered at 11:40 a.m. 5. On 5/24/2022, the 09:00 a.m. dose was documented as administered at 10:36 a.m. 6. On 5/26/2022, the 09:00 p.m. dose was documented as administered at 10:44 p.m. 7. On 5/29/2022, the 09:00 p.m. dose was documented as administered at 10:08 p.m. 8. On 6/02/2022, the 09:00 p.m. dose was documented as administered at 11:14 p.m. 9. On 6/06/2022, the 09:00 p.m. dose was documented as administered on 6/7/2022 at 01:11 a.m. 10. On 6/08/2022, the 09:00 p.m. dose was documented as administered on 6/9/2022 at 01:24 a.m. During an interview and record review on 6/16/2022 at 4:11 p.m . with Licensed Vocational Nurse 4 (LVN 4), Resident 1 ' s 05/2022 and 06/2022 MAR was reviewed. LVN 4 reported that the facility policy is that medications should be given one hour before or one hour after the scheduled administration time. LVN 4 stated she gives routine pain medications to Resident 1 twice during her of 11:00 p.m. to 7:00 a.m. shift. LVN 4 stated Resident 1 has screamed at her and demanded his pain medications be given whenever LVN 4 is more than an hour late in giving the resident his pain medications. LVN 4 stated that every time she administers Resident 1 ' s pain medication one hour outside of the scheduled time, it is a medication error, and she is not following facility policy. (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 0760 Level of Harm - Actual harm Residents Affected - Some	During an interview and concurrent record review on 7/7/2022 at 03:10 p.m. with Registered Nurse 1 (RN 1), Resident 1 ' s MAR for 5/2022, 6/2022 and Skilled Nursing Facility ' s (SNF) Medical Records were reviewed. RN 1 stated that Resident 1 had informed her that his scheduled pain medications, particularly his Oxycodone scheduled for 4:00 a.m. is always administered late. RN 1 stated that Resident 1 complaints of excruciating pain whenever his pain medications are given late. RN 1 stated she has been advising the other licensed nurses to give Resident 1 ' s scheduled pain medications timely. RN 1 stated that after reviewing Resident 1 ' s MAR for 5/2022 and 6/2022 , the physician ' s orders for Oxycodone and Morphine were not followed as the medications were not given timely. RN 1 stated that the plan for Resident 1 is to administer pain medications as per the physician ' s orders. RN 1 reviewed Resident 1 ' s SNF Medical Records and stated that there was no documented evidence that Resident 1 ' s pain was reassessed after being given pain medications. RN 1 stated that it is important to do a post assessment after pain medication is given to know if the pain medication was effective and that Resident 1 ' s pain has been alleviated. RN 1 stated that she has seen Resident 1 get mad and scream multiple times at the licensed nurses and staff when his pain medications were being given late. RN 1 stated that Resident 1 is continent (able to control) his bowel and bladder. RN 1 stated that he does recall instances where in Resident 1 required assistance with cleaning because he defecated on himself but was unable to recall the exact dates. During an interview and record review on 6/17/2022 at 12:01 p.m . with the Director of Nursing 1 (DON 1), Resident 1 ' s MAR for 05/2022 and 06/2022 was reviewed. DON 1 stated that each time a licensed nurse administered a medication outside of the one-hour window for the scheduled time, it is considered a late medication administration. DON 1 reviewed Resident 1 ' s MAR for 05/2022 and 06/2022 and stated that there was a total of 80 instances where in Resident 1 did not receive his Oxycodone on schedule as prescribed by the physician, and 10 instances where in Resident 1 did not receive his Morphine on schedule as prescribed by the physician. During an interview and record review on 7/7/2022 at 05:30 p.m. with the Director of Nursing 2 (DON 2), Resident 1 ' s MAR for 05/2022 and 06/2022 was reviewed. DON 2 stated that each and every time a licensed nurse administered a medication outside of the one-hour window for the scheduled time, it is considered a medication error. DON 2 reviewed Resident 1 ' s MAR for 05/2022 and 06/2022 and stated that there was a total of 80 instances where in Resident 1 did not receive his Oxycodone on schedule as prescribed by the physician, and 10 instances where in Resident 1 did not receive his Morphine on schedule as prescribed by the physician. During an interview and record review on 7/06/2022 at 6:15 p.m . with DON 2, Resident 1 ' s care plan titled, Acute/Chronic Pain revised 6/17/2022 was reviewed. DON 2 stated that the facility policies were not followed as the licensed nurses did not administer pain medication as per physician ' s orders. A review of the facility's policy and procedure titled, Medication Administration- General Guidelines, dated 4/2008, indicated that Medications are administered in accordance with written orders of the attending physician, medications are administered within 60 minutes of scheduled time (one hour before and one hour after). B. A review of Resident 2 ' s Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included paraplegia (loss of movement and sensation in both legs, sometimes, part of the lower abdomen) and dorsalgia (physical discomfort occurring anywhere on the spine or back, ranging from mild to disabling). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

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F 0760 Level of Harm - Actual harm Residents Affected - Some	A review of Resident 2 ' s History and Physical dated 12/26/2021, indicated that the resident had the capacity to understand and make decisions. A review of Resident 2 ' s MDS, dated [DATE], indicated Resident 2 is cognitively intact with skills required for daily decision making. Resident 2 was totally dependent on staff with Activities of Daily Living and required one-person extensive assistance (resident involved in activity, staff provide weight-bearing support) with dressing, toilet use, and personal hygiene. A review of Resident 2's Physicians Order, dated 12/24/2021, indicated an order to administer Hydrocodone-Acetaminophen (Norco - a medication used to relieve pain) 5/325 mg by mouth three times a day for pain management with administration times at 9:00 a.m., at 5:00 p.m., and at 1:00 a.m. A review of Resident 2 ' s Care Plan titled, Pain, dated 4/12/2022 and revised on 6/03/2022, indicated Resident 2 will be free of any discomfort or adverse side effects from receiving pain medication. Interventions indicated were to administer analgesia (Hydrocodone-Acetaminophen 5-325mg) as per physician ' s order and evaluate the effectiveness of pain interventions. During a concurrent observation and interview on 6/3/2022 at 12:36 p.m., observed Resident 2 sitting on her bed in a high [NAME] ' s position (sitting upright with the spine straight), awake and watching television. Resident 2 stated she is paralyzed from her sternum (breastbone) to her legs, but experiences constant pain. Resident 2 stated that her scheduled pain medication of Norco has been administered to her more than an hour late on multiple occasions. Resident 2 stated it will help her more if the nurses give her pain medications on time to help make her pain more tolerable. A review of Resident 2 ' s MAR Details for 5/2022 and 6/2022 indicated that Resident 2 ' s order for Hydrocodone- Acetaminophen 5/325 mg was not followed as per the physician ' s order by: 1. On 5/01/2022, the 01:00 a.m. dose was documented as administered at 05:13 a.m. 2. On 5/02/2022, the 05:00 p.m. dose was documented as administered 5/03/2022 at 01:03 a.m. 3. On 5/03/2022, the 01:00 a.m. dose was documented as administered at 06:25 a.m. 4. On 5/03/2022, the 09:00 a.m. dose was documented as administered at 10:58 a.m. 5. On 5/03/2022, the 05:00 p.m. dose was documented as administered at 08:43 p.m. 6. On 5/04/2022, the 01:00 a.m. dose was documented as administered at 06:22 a.m. 7. On 5/05/2022, the 01:00 a.m. dose was documented as administered at 06:03 a.m. 8. On 5/06/2022, the 01:00 a.m. dose was documented as administered at 06:19 a.m. 9. On 5/06/2022, the 09:00 a.m. dose was documented as administered at 10:36 a.m. 10. On 5/06/2022, the 05:00 p.m. dose was documented as administered 5/07/2022 at 12:03 a.m. 11. On 5/07/2022, the 01:00 a.m. dose was documented as administered at 06:15 a.m. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	12. On 5/07/2022, the 09:00 a.m. dose was documented as administered at 10:50 a.m. 13. On 5/07/2022, the 05:00 p.m. dose was documented as administered at 12:56 a.m. 14. On 5/08/2022, the 09:00 a.m. dose was documented as administered at 10:34 a.m. 15. On 5/09/2022, the 09:00 a.m. dose was documented as administered at 10:34 a.m. 16. On 5/09/2022, the 05:00 p.m. dose was documented as administered at 06:31 p.m. 17. On 5/10/2022, the 01:00 a.m. dose was documented as administered at 06:11 a.m. 18. On 5/10/2022, the 09:00 a.m. dose was documented as administered at 10:38 a.m. 19. On 5/10/2022, the 05:00 p.m. dose was documented as administered at 06:31 p.m. 20. On 5/12/2022, the 01:00 a.m. dose was documented as administered at 06:14 a.m. 21. On 5/12/2022, the 05:00 p.m. dose was documented as administered at 06:45 p.m. 22. On 5/13/2022, the 09:00 a.m. dose was documented as administered at 10:35 a.m. 23. On 5/15/2022, the 01:00 a.m. dose was documented as administered at 06:09 a.m. 24. On 5/16/2022, the 01:00 a.m. dose was documented as administered at 02:41 a.m. 25. On 5/16/2022, the 05:00 p.m. dose was documented as administered at 07:08 p.m. 26. On 5/17/2022, the 01:00 a.m. dose was documented as administered at 06:15 a.m. 27. On 5/17/2022, the 09:00 a.m. dose was documented as administered at 10:58 a.m. 28. On 5/17/2022, the 05:00 p.m. dose was documented as administered at 06:16 p.m. 29. On 5/18/2022, the 01:00 a.m. dose was documented as administered at 07:40 a.m. 30. On 5/19/2022, the 01:00 a.m. dose was documented as administered at 06:39 a.m. 31. On 6/01/2022, the 01:00 a.m. dose was documented as administered at 06:04 a.m. 32. On 6/02/2022, the 01:00 a.m. dose was documented as administered at 05:57 a.m. 33. On 6/03/2022, the 01:00 a.m. dose was documented as administered at 06:19 a.m. 34. On 6/03/2022, the 05:00 p.m. dose was documented as administered at 10:59 p.m. 35. On 6/04/2022, the 01:00 a.m. dose was documented as administered at 06:11 a.m. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	36. On 6/05/2022, the 01:00 a.m. dose was documented as administered at 03:13 a.m. 37. On 6/05/2022, the 05:00 p.m. dose was documented as administered at 09:19 p.m. 38. On 6/06/2022, the 01:00 a.m. dose was documented as administered at 04:10 a.m. During an interview and concurrent record review on 7/6/2022 at 01:18 p.m. with Licensed Vocational Nurse 1, Resident 2 ' s MAR for 05/2022, 06/2022, and Resident 2 ' s SNF medical records was reviewed. LVN 1 stated that she provides pain medication to Resident 2 during her shift of 7:00 a.m. to 3:00 p.m. LVN 1 stated after reviewing Resident 1 ' s MAR for 5/2022 and 6/2022 that there was a total of 38 entries that indicated Resident 2 received his scheduled Norco pain medications late. LVN 1 stated that after reviewing Resident 2 ' s MAR dated 5/2022 and 6/2022, she administered the resident ' s Norco late a total of 12 times. LVN 1 reported that she did not follow the facility policy and procedure that medications should be given within one hour before or one hour after the scheduled administration time. LVN 1 reviewed Resident 2 ' s SNF medical records and stated that there was no documented evidence that a post pain assessment was done after the resident had been given pain medications. LVN 1stated that they did not follow Resident ' s 2 care plan titled, Pain dated 4/12/2022, which indicated to assess pain after administering analgesic. LVN 1 stated there should be a post pain assessment for routine medications to evaluate the effectiveness of the analgesic. A review of the facility's policy and procedure titled, Medication Administration- General Guidelines, dated 4/2008, indicated that Medications are administered in accordance with written orders of the attending physician, medications are administered within 60 minutes of scheduled time (one hour before and one hour after). C. A review of Resident 3 ' s Face Sheet indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anxiety (feelings of uneasiness) and depression (feelings of sadness). A review of Resident 3 ' s MDS, dated [DATE], indicated Resident 3 had intact cognition with skills required for daily decision making. The MDS further indicated that Resident 3 required one-person extensive assistance (resident involved in activity, staff provide weight-bearing support) with dressing, toilet use, and personal hygiene. A review of Resident 3 ' s Physician ' s Orders indicated the following: 1. Methadone (medication to treat pain) Solution 10 mg/5 milliliters (ml, a unit of measure)- give 7.5 mg. by mouth three times a day for polyneuropathy (damage to many nerves that can cause pain and loss of sensation), dated 4/17/2022. 2. Methadone Solution 5 mg/5 ml- give 7.5 mg. by mouth three times a day for polyneuropathy, dated 3/08/2022. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	During an interview with Resident 3 on 6/17/2022 at 10:25 a.m., Resident 3 stated that when she receives her prescribed methadone late, the pain doubles and takes longer to bring the pain under control, which then makes it difficult to move. Resident 3 stated she has cried several times due to the pain. Resident 3 stated, many times she does not receive her pain medications on time and is often left waiting for over an hour. Resident 3 stated Licensed Vocational Nurse 5 (LVN 5) is one of the nurses that often gives her prescribed dose of methadone late. A review of Resident 3 ' s Care Plan titled, Acute Pain, initiated 6/16/2022 , indicated a goal that Resident 3 will be free from pain/discomfort. One of the interventions indicated was to administer pain medications per physician ' s order. A review of Resident 3 ' s MAR Details for 5/2022 and 6/2022 indicated that Resident 3 ' s order for Methadone 7.5 mg. was not followed as per the physician ' s order by: 1. On 5/02/2022, the 8:00 p.m. dose was documented as administered at 9:40 p.m. 2. On 5/04/2022, the 1:00 p.m. dose was documented as administered at 2:18 p.m. 3. On 5/10/2022, the 8:00 p.m. dose was documented as administered on 5/11/2022 at 12:06 a.m. 4. On 5/13/2022, the 8:00 p.m. dose was documented as administered at 11:50 p.m. 5. On 5/16/2022, the 8:00 p.m. dose was documented as administered at 10:43 p.m. 6. On 5/17/2022, the 8:00 p.m. dose was documented as administered at 9:20 p.m. 7. On 5/18/2022, the 8:00 p.m. dose was documented as administered at 9:27 p.m. 8. On 5/24/2022, the 8:00 p.m. dose was documented as administered at 11:05 p.m. 9. On 5/28/2022, the 8:00 p.m. dose was documented as administered at 9:17 p.m. 10. On 5/31/2022, the 8:00 p.m. dose was documented as administered at 11:04 p.m. 11. On 6/03/2022, the 8:00 p.m. dose was documented as administered at 9:55 p.m. 12. On 6/07/2022, the 8:00 p.m. dose was documented as administered on 6/08/2022 at 12:01 a.m. 13. On 6/14/2022, the 8:00 p.m. dose was documented as administered on 6/15/2022 at 12:49 a.m. 14. On 6/21/2022, the 8:00 p.m. dose was documented as administered at 9:42 p.m. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	During a concurrent interview and record review on 7/07/2022 at 4:00 p.m . with LVN 5, Resident 3 ' s MAR for 5/2022 and 6/2022 was reviewed. LVN 5 stated that after reviewing Resident 3 ' s MAR for 5/2022 and 6/2022, there were a total of nine instances where she documented one hours past the scheduled time of administering Resident 3 ' s methadone. LVN 5 stated that the late administrations on the MAR were due to having computer documentation issues. When asked to provide any other documented evidence that the medications were given timely as the MAR indicated that there were nine instances of late methadone administration by LVN 5, LVN 5 was not able to explain nor show additional evidence to show that the medications were administered as scheduled. During an interview with the Assistant Director of Nurses (ADON) on 6/06/2022 at 12:55 pm., ADON stated that pain medications are to be given on time, either one hour before the scheduled time or one hour after the scheduled time. The ADON stated if a pain medication is given late, then a resident can have increased pain that is difficult to control. During a concurrent interview and record review on 7/06/2022 at 4:18 p.m. with DON 2, Resident 3 ' s MAR for 5/2022 and 6/2022 was reviewed. The DON stated that the MAR indicated that Resident 3 received.14 doses of Methadone late. A review of the facility's policy and procedure titled, Medication Administration- General Guidelines, dated 4/2008, indicated that Medications are administered in accordance with written orders of the attending physician, medications are administered within 60 minutes of scheduled time (one hour before and one hour after). D. A review of Resident 5 ' s Face Sheet indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included low back pain (physical discomfort occurring anywhere on the spine or back) and discitis (an infection in the spinal cord). A review of Resident 5 ' s History and Physical dated 12/31/2021, indicated that the resident had the capacity to understand and make decisions. A review of Resident 5 ' s MDS, dated [DATE], indicated Resident 5 is cognitively intact with skills required for daily decision making, requires limited assistance during bed mobility, transfers, dressing, toilet use and personal hygiene with one-person physical assistance. A review of Resident 5's Physicians Order, dated 3/04/2022, indicated an order to administer Hydrocodone-Acetaminophen 5/325 mg by mouth every six hours as needed for severe pain (pain rating of 8-10 out of a pain scale of 0 to 10, where 10 is the worst pain).not to exceed 3 grams of Acetaminophen in a 24-hour period. A review of Resident 5's Physicians Order, dated 3/04/2022, indicated an order to discontinue Hydrocodone-Acetaminophen (Norco) 7.5/325 mg by mouth every six hours as needed for severe pain, pain scale of 8-10, not to exceed 3 grams of Acetaminophen in a 24-hour period. A record review of the dispensing record from pharmacy indicated an order for Res

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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** 45579 Based on interview and record review, the facility failed to ensure that licensed nursing staff maintained accurate medical records in accordance with accepted professional standards for one of six sampled residents (Resident 6) when Licensed Vocational Nurse 5 (LVN 5) failed to document the administration of the medications on Resident 6 ' s Medication Administration Record (MAR [a flow sheet for charting the dispensed prescribed medication for the resident). This deficient practice had the potential to result in confusion in the care and services provided to the residents, which could place the residents at risk of not receiving appropriate care due to inaccurate and incomplete resident medical care information. Findings: A review of Resident 6 ' s Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (the body ' s inability to control sugar levels in the blood), hypertension (high blood pressure), and depression (feelings of sadness). A review of Resident 6 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/21/2022, indicated Resident 6 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. A review of Resident 6 ' s Physician ' s Orders indicated the following: 1. Atorvastatin Calcium (a medication to lower cholesterol) tablet 10 milligram (mg.-a unit of measure) by mouth at bedtime for hypercholesterolemia (high levels of cholesterol in the blood), with order start date of 1/19/2022. 2. Insulin Glargine Solution (an injectable medication to treat diabetes mellitus) 100 units (U-unit of measure)/milliliter (ml-unit of measure) (an injectable medication to treat diabetes mellitus) - inject 26 units subcutaneously (into the fat underneath the skin) at bedtime. 3. Trazadone (a medication for depression) tablet 150 mg. by mouth at bedtime for depression manifested by inability to sleep, with order start date of1/19/2022. 4. Xarelto (blood thinning medication) tablet 20 mg. by mouth in the evening for deep vein thrombosis (DVT-A blood clot in a deep vein, usually in the legs which can loosen and lodge in the lungs) prophylaxis (a medication to prevent a condition), with order start date of 1/19/2022. 5. Augmentin (an antibiotic to treat bacterial infection) tablet 875-125 mg by mouth two times a day for abnormal chest x-ray result for 7 days, with order start date of5/13/22. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Carvedilol (a medication for HTN) 3.125 tablet mg by mouth every twelve hours for hypertension, hold for systolic blood pressure (the top number of the blood pressure, measuring pressure when the heart is pumping blood through the blood vessels) is less than 110 or heart rate is less than 60 beats per minute, with order start date of2/02/2022. 7. Colace (medication to soften bowel movements) capsule 200 mg by mouth two times a day for bowel management, with order start date of1/20/2022. 8. Ferrous Sulfate tablet (iron tablet to help red blood cells) 325 mg by mouth two times a day for anemia (low red blood cell count), with order start date of 1/19/2022. 9. Carisoprodol (muscle relaxer) 325 mg capsule by mouth every eight (8) hours for muscle spasms, with order start date of1/20/2022. 10. Gabapentin (medication used to treat nerve pain) 300 mg capsule by mouth three times a day for neuropathy (numbness in hands and/or feet), with order start date of 1/20/2022. 11. Repaglinide (medication to help control blood sugar levels) tablet 0.5 mg. by mouth three times a day for diabetes, with order start date of 2/28/2022. 12. Regular Insulin (medication used to lower sugar in the blood), inject per sliding scale, subcutaneously before meals and at bedtime, related to diabetes mellitus, with order start date of 1/19/2022: If 70 - 149 mg/ deciliter (dL-unit of measure), then give 0 units If 150 - 199 mg/dL, then give 2 units If 200 - 249 mg/dL, then give 4 units If 250 - 299 mg/dL, then give 6 units If 300 - 349 mg/dL, then give 8 units If 350 - 400 mg/dL, then give 10 units If above 400 mg/dL, then give 12 units and call the physician A review of Resident 6 ' s 5/2022 MAR indicated there was no nursing documentation for the following dates and medications: 1. Atorvastatin Calcium 10 mg for 5/10/2022, 5/16/2022 5/17/2022, 5/21/2022 and 5/24/2022 at 9 pm. 2. Insulin Glargine Solution 100 units/ml, 26 units for 5/10/2022, 5/16/2022 5/17/2022, 5/21/2022 and 5/24/2022 at 9 pm. 3. Trazadone tablet 150 mg for 5/10/2022, 5/16/2022 5/17/2022, 5/21/2022 and 5/24/2022 at 9 pm. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Xarelto table 20 mg for 5/10/2022, 5/16/2022 5/17/2022, and 5/24/2022 at 6 pm. 5. Augmentin tablet 875-125 mg, 5/16/22 and 5/17/22 at 5 pm. 6. Carvedilol table 3.125 mg for 5/10/2022, 5/16/2022 5/17/2022, 5/21/2022 and 5/24/2022 at 9pm. 7. Colace 200 mg for 5/10/2022, 5/16/2022 5/17/2022, and 5/24/2022 at 5 pm. 8. Ferrous Sulfate 325 mg. tablet, 5/10/2022, 5/16/2022 and 5/24/2022 at 5 pm. 9. Carisoprodol tablet 350 mg. for 5/10/2022, 5/16/2022 5/17/2022, 5/21/2022 and 5/24/2022 at 10 pm. 10. Gabapentin 300 mg. for 5/10/2022, 5/16/2022 5/17/2022, and 5/24/2022 at 5 pm. 11. Repaglinide tablet 0.5 mg. for 5/10/2022, 5/16/2022 5/17/2022, and 5/24/2022 at 4:30 pm. 12. Blood sugars and regular insulin sliding scale if needed for:: a. 5/10/2022 for 4:30 pm. and 9:00 pm. b. 5/16/2022 for 4:30 pm. and 9:00 pm. c. 5/17/2022 for 4:30 pm. and 9:00 pm. d. 5/21/2022 for 9:00 pm. e. 5/24/2022 for 4:30 pm. and 9:00 pm. During a record review and concurrent interview with the Assistant Director of Nurses (ADON) on 6/06/2022 at 12:55 pm., Resident 6 ' s 5/2022 MAR was reviewed. The ADON stated if a medication is given to a resident, the licensed nurse must document on the MAR so that the next shift would know that the medication was given. The ADON stated this was important to ensure that licensed nurses document in the MAR after administering a medication to avoid that Resident 6 would not receive an untimely dose of a medication. During a concurrent interview and record review a with Licensed Vocational Nurse 5 (LVN 5) on 6/7/2022 at 4:30 pm., Resident 6 ' s 5/2022 MAR was reviewed. LVN 5 stated she worked on 5/10/22, 5/16/2022, 5/17/2022, 5/21/2022 and 5/24/2022 and she gave Resident 6 his scheduled medications on those days. LVN 5 confirmed that on those dates, she did not document on Resident 6 ' s MAR as having given the routine medications. LVN 5 stated she should have documented the medications immediately after giving them to Resident 6. A review of the facility ' s policy and procedure titled, Medication Administration -General Guidelines, reviewed 2/16/2022, indicated the individual who administers the medication dose records the administration on the resident ' s MAR directly after the medication is given. The policy indicated in no case should the individual who administered the medication report off-duty without first recording the administration of any medications.