STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. Building B. Wing	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ellison John Transitional Care Center	43830 10th Street West Lancaster, CA 93534

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44376 Based on observation, interview, and record review, the facility failed to ensure a resident who was at risk for fall had a call light within the resident's reach (an alerting device for nurses or other nursing personnel to assist a resident when in need for one out of eight seven residents (Resident 77). This deficient practice placed the resident at risk for injury for not having a way to reach staff when help is needed. Findings: A review of Resident 77's Admission Record indicated that the facility admitted the resident on 11/1/2019 and was readmitted the resident on 1/8/2022, with diagnoses including disorders of brain, epilepsy (a common condition that affects the brain and causes frequent seizures), and muscle weakness. A review of Resident 77's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/15/20223, indicated that the resident usually had the ability to make self-understood and understand others. The MDS indicated that the resident had highly impaired vision. The MDS further indicated that the resident required extensive assistance on bed mobility, dressing, and toilet use. The resident was totally dependent on transfer, locomotion on and off unit, eating, and personal hygiene. A review of Resident 77's Care Plan, revised on 8/10/2022, indicated that the resident was at risk for falls and injuries. The care plan indicated an intervention to encourage the resident to call for assistance in ambulation. During an observation and interview on 1/30/2023, at 11:20 a.m., with Registered Nurse 3 (RN 3), observed Resident 77's call light was coiled and dangling underneath the right upper side rail of the resident's bed. RN 3 stated that it will be hard for the resident to reach the call light and could result in the resident unable to call for help increasing the resident's risk for fall. During an interview on 2/2/2023, at 11:18 a.m., with the Assistant Director of Nursing (ADON), the ADON stated that the resident should have the call light within easy reach so the resident can ask for help and prevent a fall. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's recent policy and procedure titled Fall Management Program, dated 2/25/2028, indicated to position call bell, urinal if applicable, bedside stand within reach. Place bed in lowest position with brakes locked. A review of the facility's recent policy and procedure titled Communication- Call System, dated 11/28/2022, indicated the purpose of the policy was to provide a mechanism for residents to promptly communicate with Nursing Staff. Call cords will be placed within the resident's reach in the resident's room.

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 43988 Based on observation, interview, and record review, the facility failed to protect and facilitate the resident rights to examine the results of the most recent survey (a survey to determine compliance with state and federal regulations) of the facility by failing to: 1. Ensure seven of seven residents who attended the Resident Council meeting knew where to locate the most recent survey results. 2. Post the most recent survey results in a place readily accessible (a place where individuals wishing to examine survey results do not have to ask to see them) to residents, family members, and legal representatives of residents. These deficient practices had the potential to impede the resident rights and negatively affect residents' psychosocial wellbeing. Findings: During observations on 1/30/2023 at 7:50 a.m. and 1/31/2023 at 7:35 a.m., the most recent survey results were not in a readily accessible location at the facility main entrance lobby or other location in the facility. Observed survey binder behind the wall of the reception desk obstructed from view by another binder. During the Resident Council meeting on 1/31/2023 at 1:44 p.m., seven of seven residents raised their hands to indicate they did not know where to find the most recent survey results when asked by the surveyor, Without having to ask, were the results of the state inspection available to read?. During an interview on 1/31/2023 at 2:45 p.m., the Activities Director (AD) stated the result of the most recent survey was located at the reception desk. The AD stated that residents were reminded during the resident council meeting where to find the most recent survey results. During an observation and interview on 11/22/2022 at 4:58 p.m., the Director of Nursing (DON) stated the most recent survey results binder is located by the reception desk in the front lobby. The DON stated residents should be able to access the survey results. The DON located the survey binder behind the wall of the reception desk, obstructed from view with another binder. The DON stated the binder should not be behind the wall of the reception desk and the label Survey Binder's font should have been bigger and should have been placed on top of a table in the lobby. The DON stated residents should not have to ask for assistance to get the binder and should have made the survey results binder accessible to all residents, even the ones in the wheelchair. (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy and procedure titled, Resident Rights, last reviewed 11/28/2022, indicated the purpose of the policy was to promote and protect the rights of all residents at the facility. All residents have the right to a dignified existence, self-determination, and communication with the access to persons and services inside and outside the facility including those specified in this policy. The facility will protect and promote the rights of the resident and provide equal access to quality of care regardless of diagnosis, severity of condition, or payment source. State and federal laws guarantee certain basic rights to all residents of the facility these rights include a resident's right to examine survey results. A review of the facility policy and procedure titled, Compliance with Laws and Professional Standards, last reviewed 11/28/2022, indicated the purpose of the policy was to ensure the facility staff provide services in compliance with federal, state, and local laws, regulations, codes, and professional standards, as applicable. The facility will post in a place readily accessible to residents, family members, and legal representatives of residents, the results of the most recent survey of the facility. Readily Accessible means that the individual(s) wishing to examine the most recent survey results should not have to ask to see them (e.g., posted on an accessible wall).

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 34659 Based on observation, interview, and record review, the facility failed to provide privacy for one (Resident 79) of one resident investigated for privacy when the electronic health record was left opened and unattended by staff. This deficient practice violated Resident 79's right to privacy and confidentiality of their medical records. Findings: A review of the facility's Daily Census (a listing of all the residents in the facility for that day), dated 1/30/2023, indicated Resident 79 was a resident residing in station one. During an observation on 1/30/23 at 12:08 p.m., observed Medication Cart 1 Station 1 unattended, with the computer screen open with Resident 79's name and information open so that others walking by the medication cart could see the resident's medical record. Did not observe licensed nursing staff at the computer and did not observe licensed nursing staff walking away from the computer. After a minute, Licensed Vocational Nurse 4 (LVN 4) came to the computer and closed the screen. LVN 4 stated she should have closed it when she stepped away from the medication cart. LVN 4 stated it could expose residents' information to those who should not see them. During an interview with the Director of Nurses (DON) on 2/02/23 at 10:09 a.m., she stated LVN 4 should have locked the medication cart when stepping away. The DON stated it is important to maintain residents' privacy. The DON stated leaving a computer open could expose Resident 79's records to someone who should not see them. A review of the facility's policy and procedure titled Electronic Protected Health Information Security, reviewed 11/28/2022, indicated when not in use, laptops or other mobile electronic devices should be stored in a physically secure location.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards to six out of seven sampled residents (Residents 139, 110, 66, 121, 98, and 97) by: 1. Failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin (a hormone that lowers the level of sugar in the blood) and Lovenox (medication that helps prevent the formation of blood clots) administration sites to Residents 139, 110, 66, 121, and 98. These deficient practices had the potential to cause unnecessary tissue trauma and hardening of the area where frequent subcutaneous administration occurred that could lead to impaired absorption (a condition in which the body takes in another substance) of insulin and Lovenox. 2. Attempting to take the blood pressure on the left arm of Resident 97 with thrombosis (occurs when blood clots block the blood vessels) and acute embolism (a blockage of a pulmonary [lung] artery) on left upper extremity, despite a sign on the wall indicating no blood pressure on the left arm. This deficient practice had the potential to dislodge a clot that could travel to the heart causing a heart attack, or the brain causing a stroke. Findings: a. A review of Resident 139's Admission Record indicated that the facility admitted the resident on 12/30/2022, with diagnoses including acute respiratory failure (a condition that happens when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide), diabetes type II (an impairment in the way the body regulates and uses sugar as fuel), and cerebral infarction (occurs as a result of disrupted blood flow to the brain). A review of Resident 139's History and Physical (H&P), dated 1/12/2023, indicated that the resident had the capacity to understand and make decisions. A review of Resident 139's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/4/2023, indicated that the resident sometimes had the ability to make self-understood and had the ability to understand others. The MDS further indicated that the resident required total dependence on bed mobility, transfer, and locomotion on and off unit. The MDS also indicated that the resident was on an anticoagulant (a substance that is used to prevent and treat blood clots in blood vessel and the heart) and insulin injections. A review of Resident 139's Order Summary Report, dated 1/1/2023, indicated an order for: -Enoxaparin sodium injection Solution prefilled syringe 40 milligrams (mg, a unit of mass or weight)/0.4 milliliters (ml, a unit of volume) (Enoxaparin Sodium) inject 0.4ml subcutaneously (beneath, or under the layers of the skin) (one time a day for Deep Vein Thrombosis (DVT, a medical condition that occurs when blood clot forms in a deep vein) Prophylaxis (PPX, an attempt to prevent disease). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lantus SoloStar subcutaneous solution pen-injector 100 unit/ml (a measure of how much insulin is packed into each milliliter of the fluid) (Insulin Glargine) inject 10 unit subcutaneously one time a day for diabetes mellitus (DM). -Insulin Aspart Injection solution 100 unit/ml (Insulin Aspart) inject per sliding scale (varies the dose of insulin based on blood glucose [sugar] level): if 180-200= 3 units if blood sugar is less than (BS<) 70 give 8 ounces (oz, unit of weight) of orange juice if conscious, notify MD; 201-230= 4 units; 231-260=5 units; 261-290=7 units; 291-320=9 units; 321-350=11 units if BS 351 or greater give 13 units and notify MD, subcutaneously every 6 hours for DM hold if BS<100, FSBS using test strips (an easy way to test blood sugar) and lancets (to [NAME] the finger for a blood sample), rotate sites. A review of Resident 139's Care Plan, initiated on 1/3/2023, indicated that the resident was at risk for: -Bleeding, bruising, and/or skin discoloration related to anticoagulant therapy. -Hypo (low blood sugar)/hyperglycemia (high blood sugar) related to diagnosis of DM. A review of Resident 139's Location of Administration Report on 1/1/2023 thru 1/31/2023 indicated: -Lovenox sodium injection solution prefilled syringe 40 mg/0.4 ml 1/3/2023 at 1:03 a.m. Left Upper Quadrant of the Abdomen (Abdomen-LUQ) 1/4/2023 at 12:14 p.m. Abdomen- LUQ 1/5/2023 at 12:18 p.m. Left Lower Quadrant of the Abdomen (Abdomen- LLQ) 1/6/2023 at 8:12 a.m. Abdomen- LLQ 1/17/2023 at 10:59 a.m. Abdomen- LUQ 1/18/2023 at 3:06 p.m. Abdomen- LUQ 1/24/2023 at 4:12 p.m. Abdomen- LLQ 1/25/2023 at 3:05 p.m. Abdomen- LLQ 1/26/2023 at 8:29 a.m. Abdomen- LLQ 1/27/2023 at 9:53 a.m. Abdomen- LLQ -Insulin Aspart injection solution 100 unit/ml 1/14/2023 at 12:04 a.m. Abdomen- LUQ 1/14/2023 at 6:16 a.m. Abdomen- LUQ (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/14/2023 at 12 p.m. Abdomen- LUQ 1/25/2023 at 7:50 a.m. Abdomen- LLQ 1/25/2023 at 3:05 p.m. Abdomen- LLQ During a concurrent record review and interview on 1/31/2023, at 11:50 a.m., Resident 139's Medication Administration Record (MAR) was reviewed with the Assistant Director of Nursing (ADON). The ADON stated that there were repeated administration sites of Lovenox and Aspart Insulin subcutaneous medications on the MAR and the sites of administration should be rotated to prevent tissue damage to residents receiving the medication. b. A review of Resident 110's Admission Record indicated that the facility admitted the resident on 5/6/2022, with diagnoses including acute respiratory failure, acute embolism, and thrombosis of unspecified deep veins of right lower extremity, and gastro-esophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach). A review of Resident 110's MDS, dated [DATE], indicated that the resident usually had the ability to make self-understood and understand others. The MDS indicated that the resident required extensive assistance on bed mobility, total dependence on transfer and locomotion on and off unit. The MDS further indicated that the resident was on an anticoagulant. A review of Resident 110's Order Summary Report, indicated -Enoxaparin sodium injection solution prefilled syringe 100 mg/ml (Enoxaparin Sodium) inject 100 mg subcutaneously every 12 hours for DVT Prophylaxis (long-term therapy non-ambulatory) rotate site of injection, with order date of 12/26/2022, and was discontinued on 12/29/2022. -Enoxaparin Sodium Injection Solution Prefilled Syringe 40 mg/ml (Enoxaparin Sodium) inject 100mg subcutaneously every 12 hours for DVT Prophylaxis (long-term therapy non-ambulatory) rotate site of injection with order date of 12/29/2022 and was discontinued on 1/20/2023. A review of Resident 110's Care Plan, revised on 1/4/2023, indicated that the resident was at risk for bleeding, bruising, and/or skin discoloration related to anticoagulant therapy. The care plan also indicated an intervention to administer medications as ordered and monitor for side effects. A review of Resident 110's Location of Administration Report on 1/1/2023 thru 1/31/2023 indicated: -Enoxaparin sodium injection solution prefilled syringe 100 mg/ml 1/1/2023 at 9:06 p.m. Right Lower Quadrant of the Abdomen (Abdomen- RLQ) 1/2/2023 at 11:38 a.m. Abdomen- RLQ 1/4/2023 at 9:13 p.m. Abdomen- RLQ 1/5/2023 at 10:20 a.m. Abdomen- RLQ (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/16/2023 at 9:27 a.m. Abdomen- RLQ 1/16/2023 at 8:05 p.m. Abdomen- RLQ 1/17/2023 at 8:02 a.m. Abdomen- RLQ 1/17/2023 at 9:11 p.m. Abdomen-LUQ 1/18/2023 at 10:03 a.m. Abdomen- LUQ During a concurrent record review and interview on 2/2/2023, at 10:19 a.m., Resident 110's MAR was reviewed with the ADON. The ADON stated that there were repeated sites of administration of Lovenox in the MAR and the staff should have rotated the sites of Lovenox administration to prevent undue bleeding and bruising. ADON further stated that the deficient practice had the potential for residents to develop side effects of the medication Lovenox such as bruising, bleeding, pain, and tenderness on the site of injection. c. A review of Resident 66's Admission Record indicated that the facility admitted the resident on 2/26/2019 and was readmitted on [DATE], with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), diabetes type II, and gastrostomy status (a tube inserted through the wall of the abdomen directly into the stomach). A review of Resident 66's MDS, dated [DATE], indicated that the resident rarely/never had the ability to make self-understood and understand others. The MDS further indicated that the resident was on insulin injections. A review of Resident 66's Order Summary Report indicated an order for: -Insulin Glargine solution 100 unit/ml, inject 10 unit subcutaneously at bedtime for diabetes Finger Stick Blood Sugar (FSBS, an easy way to measure the amount of sugar in your body) using lancets and test strips. Rotate injection sites. If BS <70 and patients is awake, give orange juice (OJ)/snack, if resident is unresponsive give glucagon 1 milligrams per deciliter (mg/dl, a unit of measure that shows the concentration of a substance in a specific amount of fluid) Intramuscular (IM, a technique to deliver a medicine deep into the muscles) and call MD, with order date of 6/29/2022. -Humalog solution 100 unit/ml (Insulin Lispro), inject as per sliding scale: if 70-149= 0 if BS <70, give OJ via g-tube and call MD. If not awake, give IM Glucagon 1mg and call MD; 150-199= 1 unit; 200-249=2 units; 250-299=4 units; 300-349=5 units; 350-399= 6 units if BS >400 give 8 units of insulin and notify MD, subcutaneously every 6 hours for DM2 FSBS using test strips and lancets. Rotate injection sites, with order date of 5/24/2022. A review of Resident 66's Care Plan, initiated on 5/25/2022, indicated that the resident was at risk for hypo/hyperglycemia related to diagnosis of DM. A review of Resident 66's Location of Administration Report on 1/1/2023 thru 1/31/2023 indicated: -Insulin Glargine solution 100 unit/ml (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/6/2023 at 12:13 a.m. Abdomen- LLQ 1/7/2023 at 12:07 a.m. Abdomen- LLQ 1/12/2023 at 11:45 p.m. Abdomen- LLQ 1/13/2023 at 11 p.m. Abdomen- LLQ 1/14/2023 at 11:42 p.m. Abdomen- LLQ 1/20/2023 at 8:10 p.m. Left Arm (Arm- left) 1/21/2023 at 9:48 p.m. Arm-left 1/27/2023 at 11 p.m. Abdomen- LLQ 1/28/2023 at 2:27 a.m. Abdomen- LLQ -Humalog Solution 100 unit/ml 1/1/2023 at 5:52 p.m. Abdomen- LLQ 1/2/2023 at 12:19 a.m. Abdomen- LLQ 1/4/2023 at 5:10 a.m. Abdomen- LUQ 1/5/2023 at 5:18 a.m. Abdomen- LUQ 1/14/2023 at 12:03 a.m. Abdomen- LUQ 1/14/2023 at 5:56 a.m. Abdomen- LUQ 1/17/2023 at 1:14 a.m. Arm- left 1/17/2023 at 6:37 a.m. Arm- left 1/18/2023 at 5:13 a.m. Right Upper Quadrant of the Abdomen (Abdomen- RUQ) 1/18/2023 at 5:37 p.m. Abdomen- RUQ 1/19/2023 at 12:18 a.m. Abdomen- LLQ 1/20/2023 at 12:35 a.m. Abdomen- LLQ 1/22/2023 at 12:46 a.m. Abdomen- LUQ 1/22/2023 at 6:16 a.m. Abdomen- LUQ (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/24/2023 at 6:27 p.m. Abdomen- LLQ 1/25/2023 at 1:13 a.m. Abdomen- LLQ 1/29/2023 at 2:50 a.m. Abdomen- LLQ 1/30/2023 at 12:40 a.m. Abdomen- LLQ During a concurrent record review and interview on 1/31/2022, at 11:07 a.m., Resident 66's MAR was reviewed with Licensed Vocational Nurse 9 (LVN 9). LVN 9 stated that there were repeated insulin sites of administration on the MAR of Resident 66. LVN 9 stated that it should be rotated to prevent tissue damage and pain on the repeated administration site. During a concurrent record review and interview on 1/31/2023, at 11:50 a.m., Resident 66's MAR was reviewed with the ADON. The ADON stated that the resident was on Insulin Glargine and verified multiple instances of repeated sites of injection of insulin to the resident on the MAR. ADON stated that it should be rotated to prevent tissues damage to resident. d. A review of Resident 121's Admission Record indicated that the facility admitted the resident on 10/10/2022 and was readmitted the resident on 11/7/2022, with diagnoses including chronic respiratory failure, atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the heart] fire rapidly at the same time), and gastro-esophageal reflux disease. A review of Resident 121's H&P, dated 11/10/2022, indicated that the resident had the capacity to understand and make decisions. A review of Resident 121's MDS, dated [DATE], indicated that the resident had the ability to make self-understood and understand others. The MDs indicated that the resident required total dependence on bed mobility, transfer, and locomotion on and off unit. The MDs further indicated that the resident was on an anticoagulant. A review of the Order Summary Report, dated 11/7/2022, indicated an order for enoxaparin sodium injection prefilled syringe 40 mg/ 0.4 ml (enoxaparin sodium) Inject 40 mg subcutaneously one time a day for DVT prophylaxis. Rotate injection site. A review of Care Plan, dated 11/11/2022, indicated a care plan on the use of anticoagulant Enoxaparin Sodium related to DVT PPX. The care plan indicated to monitor/document to MAR, if necessary (PRN), signs and symptoms of anticoagulant complications: blood tinged or [NAME] blood in urine . A review of Resident 121's Location of Administration Report on 12/1/2022 thru 12/31/2022 indicated: -Enoxaparin sodium injection solution prefilled syringe 40 mg/0.4 ml 12/2/2022 at 9:19 a.m. Abdomen- RLQ (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/3/2022 at 11 a.m. Abdomen- RLQ 12/13/2022 at 10:52 a.m. Abdomen- RLQ 12/14/2022 at 10:11 a.m. Abdomen- RLQ 12/15/2022 at 9:06 a.m. Abdomen- RLQ 12/16/2022 at 10:35 a.m. Abdomen- RLQ 12/21/2022 at 9:54 a.m. Abdomen- RLQ 12/22/2022 at 9:58 a.m. Abdomen- RLQ 12/28/2022 at 9:41 a.m. Abdomen- RLQ 12/29/2022 at 8:47 a.m. Abdomen- RLQ During a concurrent record review and interview on 2/2/2023, at 10:22 a.m., Resident 121's MAR was reviewed with the ADON. The ADON stated that there were repeated administration sites of the medication Lovenox in the MAR, and the staff should have rotated the sites of Lovenox administration to prevent bleeding and bruising at the site. e. A review of Resident 98's Admission Record indicated that the facility admitted the resident on 9/24/2021 and readmitted the resident on 12/10/2022, with diagnoses including acute respiratory failure, diabetes type II, and tracheostomy status (an opening surgically created through the neck into the windpipe to allow direct access to the breathing tube). A review of Resident 98's MDS, dated [DATE], indicated that the resident rarely/never had the ability to make self-understood and understand others. The MDS indicated that the resident required total dependence on eating. The MDs further indicated that the resident was on feeding tube, requiring a therapeutic diet. The MDS also indicated that the resident was on insulin injections. A review of the Order Summary Report, indicated an order for: -Humulin R solution 100 unit/ml (Insulin Regular Human) inject as per sliding scale: if 70-149= 0 if BS<70 and patient is awake, give OJ and call MD; 150-199=1; 200-249= 3; 250-299=5; 300-349=7; 350-399=9 if > or = 400, give 10 units and call MD. Per MD on call., subcutaneously every 4 hours for type II DM using test strips and lancets. Rotate injection site, with order date of 1/31/2023. -Insulin Glargine-YGFN PEN U100 inject 20 units subcutaneously daily, with order date of 1/28/2023. A review of Resident 98's Care Plan, dated 8/22/2022, indicated a care plan for at risk for hypo/hyperglycemia related to diagnosis of DM. A review of Resident 98's Location of Administration Report on 1/1/2023 thru 1/31/2023 indicated: -Humulin R solution 100 unit/ml (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/9/2023 at 4:59 a.m. Abdomen- RUQ 1/9/2023 at 11:12 a.m. Abdomen- RUQ 1/10/2023 at 4:55 a.m. Abdomen- RLQ 1/10/2023 at 1:16 p.m. Abdomen- RLQ 1/12/2023 at 4:58 a.m. Abdomen- RLQ 1/13/2023 at 12:09 a.m. Abdomen- RLQ 1/16/2023 at 9:12 a.m. Abdomen- LLQ 1/17/2023 at 12:20 a.m. Abdomen- LLQ 1/17/2023 at 8:27 a.m. Abdomen- LLQ 1/18/2023 at 11:47 p.m. Abdomen- LLQ 1/18/2023 at 4:55 a.m. Abdomen- LUQ 1/18/2023 at 8:20 a.m. Abdomen- LUQ 1/18/2023 at 8:45 p.m. Abdomen- LUQ 1/23/2023 at 12:11 p.m. Abdomen- RLQ 1/25/2023 at 9:59 a.m. Abdomen- RLQ During a concurrent record review and interview on 1/31/2023, at 11:55 a.m., Resident 98's MAR was reviewed with the ADON. The ADON stated that there were multiple instances in the MAR that the site of administration of insulin was not rotated. The ADON stated that the staff should have rotated the sites of administration to prevent tissue injury to the site of repeated administration. f. A review of Resident 97's Admission Record indicated that the facility admitted the resident on 9/7/2022 and readmitted the resident on 10/1/2022, with diagnoses including acute embolism and thrombosis of deep veins of left upper extremity, myocardial infarction (MI, decreased or complete cessation of blood flow to a portion of the heart muscle), and presence of cardiac pacemaker (an electronic device that is implanted in the body to monitor heart rate and rhythm). A review of Resident 97's MDS, dated [DATE], indicated that the resident had the severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/30/2023, at 8:40 a.m., in Station 1 during medication pass, observed a sign on the wall of Resident 97 indicating no blood pressure on left arm. Licensed Vocational Nurse 10 (LVN 10) was observed removing the resident's left jacket sleeves and was about to take the resident's blood pressure; stopped LVN 10 and requested to check the sign on Resident 97's wall. Observed LVN 10 proceeded to check blood pressure on the right arm instead. LVN 10 stated that the resident had thrombosis and acute embolism on left upper extremity. LVN 10 stated if he had taken the blood pressure on the left arm, it could potentially cause another embolism or clot; potentially exasperate the issue. LVN 10 stated the potential risk was death, potentially cause for more clot, another myocardial infarction or stroke (occurs when something blocks blood supply to part of the brain). LVN 10 stated it was important to know his resident before caring for them. LVN 10 stated he did not know that the resident had thrombosis before he went in the room. During an interview on 02/02/23, at 11:15 a.m., with the ADON, the ADON stated that the LVN should have not attempted to take the blood pressure on the left arm it could have dislodged a clot from the left upper extremity and caused the clot to travel to the heart and the brain causing a heart attack or stroke. A review of the facility's recent policy and procedure titled Subcutaneous Injection/Insulin or Heparin, dated 11/28/2022, indicated injected sites will be rotated to avoid unnecessary trauma to tissues and aid in medication absorption. Hardened or painful areas will not be used for injection. Assess the injection site for bleeding. Apply additional pressure if necessary. Record the administration of medication and the site on the Medication Administration Record. A review of the facility's recent policy and procedure titled Anticoagulant Therapy, dated 11/28/2022, indicated the purpose of the policy was to ensure that anticoagulant therapy was safely and effectively administered. The facility will monitor residents receiving anticoagulant therapy. Instruct the resident and family regarding the side effects and adverse drug effects of anticoagulant therapy. Document the decision in the medical record. A review of the Manufacturer's Guideline on the use of Lovenox (enoxaparin sodium injection) for subcutaneous and intravenous use, with initial U.S. Approval in 1993, indicated that administration should be alternated between left and right anterolateral and left and right posterolateral abdominal wall. The whole length of the needle should be introduced into a skin fold help between the thumb and forefinger; the skin fold should be held throughout the injection. To minimize bruising, do not rub the injection site after completion of the injection. A review of the Manufacturer's Guideline on the use of Lantus (insulin glargine injection) for subcutaneous injection, with initial U.S. Approval in 2000, indicated to rotate injection sites to reduce the risk of lipodystrophy. A review of the Manufacturer's Guideline for Humalog (insulin lispro injection USP [rDNA origin]) for injection with initial U.S. approval on 1996, indicated that HUMALOG administered by subcutaneous injection should be given in the abdominal wall, thigh, upper arm, or buttocks. Injection sites should be rotated within the same region (abdomen, thigh, upper arm, or buttocks) from one injection to the next to reduce the risk of lipodystrophy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Manufacturer's Guideline on the use of Humulin R, manufactured by [NAME] Lilly and Company, Indianapolis, IN 46285, USA, undated, indicated to void tissue damage, choose a site for each injection that is at 1/2 inch from the previous injection site. The usual sites of injection are abdomen, thighs, and arms.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 38552 Based on observation, interview, and record review, the facility failed to develop and implement resident-centered activities for a resident who considered listening to music as a very important activity for one of one sampled resident (Resident 56). This deficient practice had the potential to result in a decline in the resident's physical, social and emotional functioning. Findings: A review of Resident 56's Admission Record indicated the facility admitted the resident on 12/1/2022 with diagnoses including hemiplegia (in its most severe form, complete paralysis of half of the body) and hemiparesis (is weakness of one entire side of the body) following cerebral infarction (stroke, damage to the brain from interruption of its blood supply) affecting left non-dominant side, and acute kidney failure (kidneys lose the ability to filter waste from your blood sufficiently over a period of days). A review of Resident 56's History and Physical, dated 12/3/2022, indicated the resident does not have the capacity to understand and make decisions. A review of Resident 56's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/8/2022, indicated the resident slurred or mumbled words, sometimes made self-understood, and sometimes understood others. The MDS indicated the resident's cognitive skills for daily decision making was severely impaired (never or rarely made decisions). The MDS indicated the resident required total dependence with bed mobility, transfer, dressing, toilet use, and bathing with two or more physical assistance. The MDS indicated the family or significant other as primary respondent for the resident's daily and activity preferences who stated that listening to music was a very important activity for the resident while residing in the facility. During an interview on 1/31/2023 at 11:19 a.m., the Family Member 1 (FM 1) stated she visits Resident 56's daily during lunch time. FM 1 stated she had attended the care plan meeting via teleconference meeting. FM 1 stated she had shared during the meeting the resident's preference to have the bed/music speaker she provided to be played daily preferably 24/7 but may be off at night when the resident is sleeping. FM 1 stated but every time she visits the speaker has been put away. FM 1 stated she feels Resident 56 is regressing if she has not been provided with this activity. During a concurrent observation and interview at Resident 56's bedside, on 2/1/2023 at 9:43 a.m., Certified Nursing Assistant 2 (CNA 2) confirmed the resident's music speaker and headphones were kept inside the resident's drawer. CNA 2 stated she does not know what activities the resident has. CNA 2 stated she does not know what the resident's activity preference is. CNA 2 stated the digital photo was already set up when she got here this morning. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview at Resident 56's bedside, on 2/1/2023 at 11:20 a.m., the Speech Therapist (ST, work to prevent, assess, diagnose, and treat speech, language, social communication, cognitive-communication, and swallowing disorders) stated FM 1 wanted Resident 56 to have continuous music played. The ST stated she asked the resident if she would like to listen to music and the resident nodded her head, so she placed the headphones on the resident. The ST stated FM 1 wanted the resident to have sensory stimulation, so FM 1 brought devices such as the digital photo album, headphones, and music speaker/device player for the resident. During a concurrent observation and interview at Resident 56's bedside, on 2/1/2023 at 11:28 a.m., the Activity Director (AD) confirmed that the resident has the headphones and music device brought in by FM 1. The AD stated she does not know who applies the headphones to the resident because she only conducts room visits three times a week. During a concurrent interview and record review on 2/1/2023 at 12:56 p.m., Resident 56's Documentation Survey Report dated 1/2023, was reviewed with AA., AA 1 stated activities are offered every day and room visits are done Monday through Friday. AA 1 stated room visits are done daily, and documentation of activities offered should be done daily. AA 1 confirmed that she did not sign on 1/2, 1/3, 1/4, and 1/5. AA 1 stated that the days that were not signed may have been because it was missed, or activities were not offered to the resident. AA 1 stated the resident's category of 1:1 program/Room visits and music should have been signed daily. During an interview on 2/2/2023 at 10:28 a.m., the Director of Nursing (DON) stated activities are offered to the residents daily, including weekends and evenings. The DON stated the activity staff visits the residents in the rooms and offer the activities. The DON stated the resident's care plan should be resident centered based on the resident's preferences. The DON stated for Resident 56's FM 1 provided their own music device and wants it to be played continuously for sensory stimulation. The DON stated the activity staff and the nursing staff including CNA and licensed nurses should ensure that is being provided to the resident. The DON stated the care plan should indicate which disciplines would implement the interventions including the activity care plan. The DON stated when the resident is not provided activities as care planned, it may lead to a decline in their physical, emotional, and social well-being. A review of the facility's policy and procedure titled, Activities Program, approved on 11/28/2022, indicated that the facility provides an activity program designed to meet the needs and interests, and preferences of residents. The policy indicated that a variety of activities are offered on daily basis, which includes weekends and evenings. The procedure indicated that activities staff will maintain a daily log that documents the frequency of each activity offered by the facility and which residents participate in that activity. A review of the facility's policy and procedure titled, Room Visit Program, approved on 11/28/2022, indicated that the facility will provide recreational opportunities for residents who not physically able to leave their room and the AD will develop an individualized activity care plan. Residents will be visited in their room on a regularly scheduled basis. The procedure indicated room visits may include sensory stimulation and the resident's participation in activities and Activity Staff will document the activity, the level of participation, and response to approaches will be recorded, and any additional comments regarding the visit.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43323 Based on interview and record review, the facility failed to provide the necessary treatment and services to prevent formation and progression of a pressure injury (an injury to skin and underlying tissue due to prolonged pressure over a bony structure) to the sacrococcyx (pertaining to the sacrum [large, curved, triangular-shaped bone at the base of the spine] and coccyx [tailbone]) for three of five sampled residents (Residents 93, 104, and 121) by failing the following: 1. For Resident 93: a. Failed to ensure wound weekly monitoring assessments were completed to determine the healing status of Resident 93's sacroccoccyx pressure injury. b. Failed to notify the physician on 12/27/2022 when Resident 93's wound treatment order came to an end which resulted in Resident 93 not receiving wound treatments since the last treatment was provided on 12/27/2022 and until a new treatment was ordered on 1/2/2023. c. Failed to notify the Registered Dietitian (RD) to provide nutritional recommendations to promote healing of pressure injury when Resident 93's sacrococcyx wound worsened from stage three pressure injury (full-thickness loss of skin, in which subcutaneous [beneath the skin] fat may be visible in the injury) to stage four pressure injury (full-thickness skin and tissue loss with exposed or directly palpable fascia [is a thin casing of connective tissue that surrounds every structure in the body], muscle, tendon, ligament, cartilage or bone in the injury). d. Failed to ensure Resident 93's skin checks were conducted by the Certified Nursing Assistants (CNAs) during shower days (12/23/2022, 12/26/2023, 12/30/2023, and 1/6/2023). These deficient practices resulted in Resident 93 developing a facility-acquired (developed after admission to the facility) stage three sacrococcyx pressure injury that progressed to a stage four pressure wound while in the facility. 2. Failed to document a new wound on the right buttock for Resident 104. This had the potential to result in the development of worsening and newly acquired pressure injury for Resident 104. 3. Failed to adjust the low air loss mattress based on the weight distribution for Resident 121 who had a stage three pressure injury at the sacrococcyx area. This deficient practice had the potential to cause worsening of the pressure injury on the sacrococcyx of Resident 121. Findings: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1. A review of Resident 93's Admission Record indicated the facility admitted the resident on 5/27/2021 with diagnoses of diffuse traumatic brain injury (a sudden, violent blow or jolt to the head that causes damage to the brain) with loss of consciousness of unspecified duration, generalized muscle weakness, and diabetes mellitus type two (a chronic disease characterized by high levels of sugar in the blood due to impairment in the way the body regulates and uses sugar for fuel). A review of Resident 93's Wound Weekly Monitoring Assessment - Pressure, dated 5/28/2021, indicated Resident 93 did not have a sacrococcyx wound upon admission. A review of Resident 93's Situation-Background-Assessment-Recommendation: Change of Condition (COC - system for identifying, evaluating, and reporting deterioration in resident's condition) form, dated 9/23/2022, indicated a reopened wound to sacral area. A review of Resident 93's Wound Weekly Monitoring Assessment, dated 9/24/2022, indicated a stage three sacrococcyx wound measuring 1 centimeter (cm - unit of measure) in length by 1 cm in width by 0.2 cm in depth with no undermining (erosion under the wound edges resulting in a large wound with a small opening) or tunneling (wound that has progressed to form passageways underneath the surface of the skin). A review of Resident 93's Braden Scale for Predicting Pressure Sore Risk form (Braden Scale is a standardized, evidence-based assessment tool commonly used in health care to assess and document a patient's risk for developing pressure injuries), dated 11/30/2022, indicated the resident was a high risk for developing pressure injuries. A review of Resident 93's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/30/2022, indicated Resident 93's cognitive skills (the act or process of knowing and perceiving) for daily decision making were severely impaired and was totally dependent on staff with two people assisting for bed mobility (moving to and from lying positions, turning side to side, and positioning body while in bed), transfer (moving to or from bed, chair, wheelchair, standing position), dressing, and toilet use. A review of Resident 93's Wound Consultation Notes by Wound, Ostomy (an artificial opening in an organ of the body created during an operation) and Continence Nurse 1 (WOCN 1), dated 12/16/2022, indicated a stage 3 pressure injury described as crater-like injury extending through dermis to subcutaneous tissue but not through fascia. A review of Resident 93's Wound Weekly Monitoring Assessment, dated 1/13/2023, indicated an unstageable (full thickness tissue loss in which the base of the injury is covered by slough [yellow, tan, gray, green, or brown colored dead tissue separating from living tissue] and/or eschar [collection of dry, dead tissue within a wound that appears tan, brown, or black] in the wound bed) sacrococcyx wound measuring 6 cm in length by 6 cm in width with 80% slough, 10% granulation (pink lumpy tissue that forms during wound healing), and 10% epithelialization (formation of new tissue covering the wound surface). A review of Resident 93's COC, dated 1/16/2023, indicated the resident's pressure injury had deteriorated as evidenced by increase in size and depth and that the MD had reclassified the sacrococcyx wound from stage three pressure injury to stage four pressure injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 93's Wound Weekly Monitoring Assessment - Pressure, dated 1/16/2023, indicated a stage four sacrococcyx wound measuring 8.5 cm in length by 8.5 cm in width by 4 cm in depth with undermining of 4 cm noted at 9 a.m. to 4 p.m. The assessment further indicated muscle and tendon were exposed with 30% slough, 60% granulation, and 10% epithelialization. A review of Resident 93's Care Plan, dated 1/16/2023, indicated the resident was at risk for further deterioration of stage four sacrococcyx pressure wound and indicated interventions that included monitoring and reassessing pressure injury for healing weekly, providing treatment as ordered and changing treatment when signs of healing are not noted, RD evaluation as ordered, and notifying MD for changes. A review of Resident 93's Wound Consultation Notes by WOCN 1, dated 1/17/2023, indicated the sacrococcyx wound deteriorated to stage 4 with visible muscle and bone and malodor (a very unpleasant smell) noted. The wound consultation note indicated Resident 93 was noted with slight fever of 100.4 degrees Fahrenheit (unit of measure) and signs and symptoms of infection were noted that included increased pain, increased drainage, and increased wound size. Medical Doctor 1 (MD 1) was notified of the changes. During a concurrent interview and record review, on 2/1/2023 at 10:45 a.m., Treatment Nurse 1 (TN 1) stated Resident 93 developed a stage three pressure injury on the sacrococcyx that had reopened on 9/23/2022 at the facility. TN 1 reviewed Resident 93's Wound Weekly Monitoring Assessment, dated 9/24/2022 to 1/27/2023, and stated that weekly assessments of Resident 93's sacrococcyx pressure injury were not done on 12/30/2022 and 1/6/2023. TN 1 stated she was not aware the weekly assessments were not completed until 1/13/2023 when the next weekly wound assessment was due since she was not working from 12/24/2022 to 1/2/2023 and TN 1 was not assigned to Resident 93 on 1/6/2023. TN 1 stated the treatment nurse assigned to Resident 93 on 12/30/2022 and 1/6/2023 should have assessed the wound and documented on the Wound Weekly Monitoring Assessment form. TN 1 further reviewed Resident 93's physician's order and stated the following order: Cleanse with half-strength Dakin's (solution is used to prevent and treat skin and tissue infections), pat dry, apply gentamycin (antibiotic) ointment on wound bed first, then apply thin layer of triad paste (topical wound dressing), apply skin prep to periwound (tissue surrounding a wound), and cover with foam dressing every day shift every other day for wound management for 14 days, ordered on 12/17/2022. TN 1 reviewed Resident 93's Treatment Administration Record (TAR) for December 2022 and January 2022 and stated a wound treatment was missed on 12/29/2022 which should have been the last treatment date for the specified order. TN 1 stated that no wound treatments were provided for Resident 93's sacrococcyx pressure injury since 12/27/2022 until a new treatment order was obtained from the physician on 1/2/2023, with instructions to cleanse with normal saline, pat dry, apply Medihoney (is a brand name wound and burn gel made from 100% Leptospermum [Manuka] honey), followed by calcium alginate (dressing used for moderate to heavily draining wounds), apply skin prep to periwound, and cover with foam dressing every day shift. TN 1 stated there is potential outcome for the wound to deteriorate further if treatments are missed. TN 1 stated Resident 93's sacrococcyx wound had deteriorated to a stage four pressure injury with exposed muscle and tendon when she reassessed the wound on 1/16/2023 and verified the wound had grown larger measuring 8.5 cm in length by 8.5 cm in width by 4 cm in depth with undermining of 4 cm noted. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/1/2023 at 2:08 p.m., the Assistant Director of Nursing (ADON) confirmed she worked on 12/30/2022 and was assigned to Resident 93. The ADON stated she typically does not provide wound treatments but would fill in as wound treatment nurse when needed. The ADON stated she was not aware Resident 93 had a sacrococcyx wound and stated she did not complete the weekly wound assessment for Resident 39 on 12/30/2022 since she was not aware Resident 93 was due for one. During a concurrent record review of Resident 93's TAR, the ADON stated that the facility did not provide any wound treatment to Resident 93 on 12/30/2022. The ADON stated that she was unaware at that time (12/30/2022) that Resident 93's wound treatment had been completed and that a new order had to be obtained to continue treatment for Resident 93's sacrococcyx wound. The ADON stated that had she known at that time (12/30/2022) that Resident 93 had no further wound treatments ordered for her unhealed sacrococcyx pressure injury, she would have called the registered nurse (RN) to assess and evaluate the wound with her and contact the physician to determine if any changes would need to be made to continue or order a new treatment. The ADON stated there was a potential for Resident 93's sacrococcyx wound to deteriorate further due to wound treatments not being continued and missed opportunities for assessments to monitor the progress of the wound. During a concurrent interview and record review, on 2/1/2023 at 2:28 p.m., Licensed Vocational Nurse 3 (LVN 3) stated she worked on 1/6/2023 and was assigned to residents in station 2 including Resident 93. LVN 3 reviewed Resident 93's TAR and stated the wound treatment was provided for Resident 93 on 1/6/2023. However, LVN 3 stated she did not get a chance to observe the Resident 93's sacrococcyx wound since the treatment was provided by another LVN who offered to assist her that day. LVN 3 stated that a wound assessment was not completed on 1/6/2023 and only the ordered wound treatment was done. LVN 3 stated the weekly wound assessment should have been completed to measure the wound and monitor for any changes and abnormalities that needed to be communicated to the physician promptly. LVN 3 stated there is potential for further skin issues and worsening of existing pressure injuries if skin is not assessed weekly. During a concurrent interview and record review, on 2/2/2023 at 8:50 a.m., the Registered Dietitian (RD) stated she was unaware Resident 93's sacrococcyx wound had deteriorated to a stage 4 pressure injury and confirmed that she was not notified, stating that she would have documented in the dietary/nutritional progress notes addressing the wound. The RD stated she did not receive a call from the treatment nurse and that she did not receive an autopopulated (to automatically fill a form) alert via email which should have been triggered if a resident develops a wound or has wound that has worsened. The RD reviewed Resident 93's dietary progress note, dated 1/29/2023, and stated she did not make any changes or provide new recommendations for wound management since Resident 93's most recent weekly wound assessment, dated 1/27/2023, that she reviewed indicated the sacrococcyx wound had decreased in size. The RD further stated the treatment nurse should have notified her immediately for timely interventions and recommendations for wound management since wound healing can be inhibited if interventions are not implemented promptly. The RD stated that if she had been notified, she would have made recommendations to check laboratory results for complete blood count (CBC, blood test used to look at overall health and help diagnose a medical condition), basic metabolic panel (BMP, blood test that measures the body's fluid and electrolyte balance), albumin (is a protein made by the liver), and prealbumin and reevaluated the need for zinc (essential mineral) and arginaid (a supplement) to promote wound healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review, on 2/2/2023 at 10:19 a.m., Treatment Nurse 2 (TN 2) stated she worked on 12/29/2022 and stated she was the only treatment nurse available during the day shift. TN 2 reviewed Resident 93's TAR for December 2022 and stated there was no documented evidence wound treatment was provided for Resident 93's sacrococcyx pressure injury on 12/29/2022. TN 2 stated she did not provide wound care for Resident 93 on that day. TN 2 further stated she did not call the doctor for a new wound treatment order and stated she was unaware the wound treatment for 12/29/2022 was the last scheduled treatment. TN 2 stated WOCN 1 should have been notified to ensure Resident 93 continued to receive wound treatments for her sacrococcyx pressure injury. TN 2 further stated it is important that treatments are not missed to prevent Resident 93's wound from deteriorating and prevent wound infections. During an interview, on 2/2/2023 at 10:28 a.m., LVN 8 stated she worked on 12/29/2022 and stated she did not remember providing a wound treatment for Resident 93. LVN 8 stated that Resident 93's TAR for December 2022 indicated that a wound treatment was not provided on 12/29/2022. During an interview, on 2/2/2023 at 3:45 p.m., WOCN 1 stated Resident 93's sacrococcyx pressure injury was a stage 3 and was stable and small in size when she had visited the resident on 12/16/2022. WOCN 1 stated she was on vacation starting 12/22/2022 and stated her next visit to see Resident 93 was on 1/17/2023 when she noticed Resident 93's sacrococcyx wound had suddenly worsened and deteriorated very fast. WOCN 1 stated she also found Resident 93 to have a fever of 100.4 degrees Fahrenheit and there was foul odor coming from the sacrococcyx wound. WOCN 1 confirmed Resident 93's sacrococcyx wound had increased in size with visible muscle and bone and stated the wound had progressed to a stage 4 pressure injury. WOCN 1 stated she notified Medical Doctor 1 (MD 1) and ordered a wound treatment on 1/17/2023. WOCN 1 stated since she was not available, the treatment nurse should have called MD 1 prior to when the last treatment was provided on 12/29/2022 so there is no lapse in wound treatment. During an interview, on 2/2/2023 at 5:16 p.m., the Director of Nursing (DON) stated Resident 93 did not receive wound care for her sacrococcyx pressure injury when the ordered treatment ended on 12/29/2022 until a new treatment order was obtained on 1/2/2023 upon reviewing Resident 93's TAR. During a concurrent record review of Resident 93's Wound Weekly Monitoring Assessment, dated 12/23/2022 to 1/16/2023, the DON stated there were missing assessments on 12/30/2022 and 1/6/2023. The DON stated the treatment nurses should have assessed Resident 93's sacrococcyx pressure injury and documented on the Wound Weekly Monitoring Assessment every week. The DON stated Resident 93's sacrococcyx wound was assessed to be a stage 3 pressure injury measuring 3.8 cm in length by 2.9 cm in width and 0.1 cm in depth om 12/23/2022 and that the wound had worsened to unstageable pressure injury when assessed on 1/13/2023 and further deteriorated to stage 4 pressure injury measuring 8.5 cm in length by 8.5 cm in width by 4 cm in depth when reassessed on 1/16/2023. During an interview, on 2/3/2023 at 1:19 p.m., MD 1 stated the facility did not call her to reorder wound treatment for Resident 93 between 12/27/2022 and 1/1/2023. MD 1 checked the message system and verified there were no calls received from the facility. MD 1 stated if she had been called, she would have ordered a treatment and not allowed the treatment to come to a stop or be discontinued. MD 1 stated Resident 93 has a deep stage 3 pressure injury on the sacrococcyx that requires continued treatment for wound healing. MD 1 further stated she would have consulted with WOCN 1 for treatment recommendations and would have adjusted the treatment order depending on if the wound was getting better or worse. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview, on 2/3/2023 at 2:55 p.m., the DON stated no one had been auditing the weekly wound assessments and therefore were missed. During a concurrent interview and record review, on 2/3/2023 at 3:07 p.m., the Director of Staff Development (DSD) stated the following: Certified Nursing Assistant 6 (CNA 6) did not complete the weekly skin check for Resident 93 during shower day on 12/23/2022. CNA 4 did not complete the weekly skin check for Resident 93 when shower was provided on 12/30/2022. Certified Nursing Assistant 5 (CNA 5) did not complete weekly skin checks during shower days for Resident 93 on 12/26/2022 and 1/6/2022. A review of the facility's current policy and procedure titled, Wound Management, last reviewed on 11/28/2022, indicated a resident who has a wound will receive the necessary treatment and services to promote healing, prevent infection, and prevent new pressure injuries from developing. The policy and procedure further indicated the following: A licensed nurse will perform a skin assessment upon admission, readmission, weekly, and as needed for each resident. Implement a wound treatment per physician's order. The attending physician will be notified to advise on appropriate treatment promptly. Dietary contact will be made for nutritional assessment for wound management. CNAs will complete body checks on resident's shower days and report unusual findings to the licensed nurse. Wound documentation will occur at a minimum of weekly until the wound is healed. Documentation will include: o Location of wound o Length, width, and depth measurements recorded in centimeters o Direction and length of tunneling and undermining if applicable o Appearance of wound base o Drainage amount and characteristics including color, consistency, and odor o Appearance of wound edges o Description of the peri-wound condition or evaluation of the skin adjacent to the wound (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	o Presence or absence of new epithelium at wound rim o Presence of pain 44376 2. A review of Resident 104's Admission Record indicated the facility originally admitted the resident on 3/22/2022 with diagnoses that included acute respiratory failure with hypoxia (a condition that occurs when the respiratory system cannot adequately provide oxygen to the body), stroke, and quadriplegia (paralysis of all four limbs). A review of Resident 104's MDS, dated [DATE], indicated Resident 104 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 104 required total dependence (full staff performance every time during the entire seven-day assessment period) from two-person staff assistance for bed mobility, and transfer. The MDS indicated Resident 104 had a stage III (three) pressure ulcer (a full thickness tissue loss pressure ulcer in which subcutaneous fat [fat underneath the skin that can be grabbed and pinched between the fingers] may be visible, but bone, tendon [tissue attaching a muscle to a bone], or muscle is not exposed). A review of the Resident 104's SBAR: Change of Condition Form, dated 8/06/2022, indicated Resident 104 had a new open wound to the sacrococcyx area. A review of Resident 104's Braden Scale for Predicting Pressure Sore Risk, dated 12/16/2022, indicated a score of 12 (high risk for pressure injuries). A review of Resident 104's current Care Plan for Pressure Ulcer Stage III, initiated on 9/14/2022, indicated a goal that Resident 104 will show signs of pressure ulcer healing. The care plan indicated an intervention that licensed staff will conduct treatment as ordered and change when signs of healing are not noted. The care plan indicated an intervention that licensed staff will notify the resident's physician and family for changes. A review of Resident 104's Physician's Orders indicated an order, dated 2/1/2023, to cleanse the sacrococcyx pressure sore with normal saline (a salty solution to cleanse wounds), pat dry, apply collagen (a treatment medication to stimulate wound healing) to wound bed, followed by Dermaseptin (brand name for a skin preparation, an ointment that provides a barrier to prevent irritation from moisture and to promote healing) to peri wound (tissue surrounding the wound), then apply a Duoderm (brand name for a commonly used hydrocolloid dressing [dressing to provide a moist and insulating environment to promote wound healing]) dressing, hold for 30 seconds, every day shift for wound management for 14 days. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and wound observation with Licensed Vocational Nurse 1 (LVN 6) on 2/01/2023 at 9:02 a.m., observed LVN 6 change Resident 104's sacrococcyx dressing. Observed the stage III pressure ulcer which measured 1.5 centimeters (cm, a unit of measure in length) by 1.7 cm. LVN 6 did not measure the depth. Observed a dime shaped circular area of broken skin with red base beside the stage III wound on the upper right side. LVN 6 applied the collagen as ordered to the wound and the skin prep to the surrounding skin which covered the dime shaped reddened open area. When asked what the reddened area was, LVN 6 stated the dime-shaped circular area observed in the wound treatment observation was granulated (that part of the healing process in which lumpy, pink tissue containing new connective tissue forms around the edges of a wound) and not 100% closed skin, but the first layer of the skin was removed. When asked how long circular area had been present, LVN 6 stated she did not know since there was no documentation specifically for that area of reddened area. When asked if the broken skin area was getting larger, treatment nurse stated she did not know. LVN 6 stated she had observed the broken skin before but has not measured it. LVN 6 stated she would describe the dime-shaped, red, circular broken skin as the peri-wound which was red and granulated. LVN 6 stated the wound description needed more clarification since the red, circular, dime-shaped area looks different than the skin touching and surrounding the stage III ulcer. LVN 6 stated documenting accurately is important so it can be monitored and will not increase in size. During a concurrent record review and interview with LVN 6 on 2/02/2023 at 9:45 a.m., reviewed Resident 104's August 2022 Treatment Administration Record (TAR, the form in which treatments such as dressing changes are documented after completing for that day). The TAR indicated there were blank spaces on 8/15/2022, 8/20/2022, and 8/22/2022 for Resident 104's wound treatment. When asked about those blank spaces for Resident 104's August 2022 TAR, LVN 6 stated she did not know what they indicated since she did not conduct Resident 104's wound treatments in August 2022. During an interview on 02/02/23 10:09 a.m., and concurrent record review of the facility's policy and procedure titled, Change of Condition Notification, reviewed 11/28/2022, the DON stated the part of the policy and procedure that indicated a significant change in the resident's physical status referred to development of new breakdown in skin. The DON stated, although not specifically indicated, skin breakdown is considered a significant change in condition. The policy and procedure indicated the attending physician will be notified timely with a resident's change in condition. The DON stated there should have been a change in condition form completed when the broken skin was first observed. The DON stated the resident's physician should have been notified. The DON stated it was important for the resident's physician to be aware so they can order treatment to prevent the wound from getting larger. The DON stated this open area might require different treatment than the ordered skin preparation ointment since there is open skin and is different in appearance from the rest of the skin surrounding the stage III pressure ulcer. When asked about the blank spaces on Resident 104's August 2022 TAR, she stated she could not verify the treatments were done on those dates. The DON stated if there is no documentation then there was the possibility that the treatments were not done on those days. A review of the facility's policy and procedure titled, Pressure Ulcer Prevention, reviewed 11/28/2022, indicated if a resident is identified as having a wound at any time other than admission, the Wound Monitoring Record will be implemented. The policy and procedure indicated a Wound Monitoring Record will be implemented for each identified wound. 34659 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3. A review of Resident 121's Admission Record indicated the facility admitted the resident on 10/10/2022 and was readmitted on [DATE], with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), diabetes type II (an impairment in the way the body regulates and uses sugar as fuel), and protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). A review of Resident 121's History & Physical (H&P), dated 11/10/2022, indicated that the resident had the capacity to understand and make decisions. A review of Resident 121's MDS, dated [DATE], indicated that the resident had the ability to make self-understood and understand others. The MDS indicated that the resident required total dependence on bed mobility, transfer, locomotion on and off unit, dressing, eating, toilet use, and personal hygiene. The MDS also indicated, that the resident required one to two persons' physical assist. The MDS further indicated that the resident was always incontinent of stool (feces) and the resident had an unstageable deep tissue injury (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed). The MDS indicated that the resident's weight was 143 pounds (lbs., a unit of weight). A review of the Braden Scale for Predicting Pressure Sore Risk, dated 10/10/2022, indicated that Resident 121 was at high risk for developing pressure injury. A review of Resident 121's Order Summary Report, dated 11/20/2022, indicated an order for low air loss mattress (a mattress designed to prevent and treat pressure injuries) every shift for wound management/skin management. A review of Resident 121's Wound Weekly Monitoring Assessment- Pressure, dated 1/17/2023, indicated a sacrococcyx extending to the right and left measuring 2.3 centimeters by 2.1 cm by 0.2 cm, stage III. A review of Resident 121's Care Plan, revised date 1/28/2023, indicated a care plan for pressure injury stage 3 skin integrity impaired: sacrococcyx extending to the right and left buttock. During a concurrent observation and interview on 1/30/2023, at 10:40 a.m., with Registered Nurse 3 (RN 3), observed the bed setting of the low air loss mattress of Resident 121 was maximum inflated at 250. RN 3 stated that the setting should be at 120. RN 3 further stated that the setting was probably changed when the staff changed Resident 121's incontinence pad, she was not sure how long the mattress was maximum inflated. RN 3 stated that it is not appropriate for Resident 121's weight which was only 120 to 150 lbs. If the resident had a bedsore, it would make it worse. A review of the facility's recent policy and procedure titled Pressure Ulcer Prevention, dated 11/28/2022, indicated that the purpose of the policy was to identify residents at risk for skin breakdown, implement measures to prevent and/or manage pressure ulcers and minimize complications. A review of the facility's recent policy and procedure titled Wound Management, dated 11/29/2022, indicated that an assessment of care needs for pressure ulcer and wound management will be made with emphasis on, but not limited to mechanical offloading and pressure reducing devices. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the Manufacturer's Guideline on the use of Alta [NAME] Plus 760000 Alternating Pressure/Low Air Loss Mattress System, dated 2011, indicated on pressure adjustment, generally, a lighter patient will need a lower (softer) setting while a heavier patient will need a higher (firmer) setting, but pressure adjustment must ultimately be based on the patient's weight distribution.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44376 Based on observation, interview, and record review, the facility failed to provide an environment free from accidents and hazards for one out of ten sampled residents (Resident 121) by failing to ensure Resident 121's bed was not left at working level (height of the bed when staff are providing care to residents, 3 feet); increasing the risk for falls with injury. This deficient practice placed Resident 121 at risk falls with injury. Findings: A review of Resident 121's Admission Record indicated that the facility admitted the resident on 10/10/2022 and readmitted the resident on 11/7/2022, with diagnoses including chronic respiratory failure with hypoxia (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe to help breathe), and muscle weakness. A review of Resident 121's History and Physical (H&P), dated 11/10/2022, indicated that the resident had the capacity to understand and make decisions. A review of Resident 121's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/14/2022, indicated that the resident had the ability to make self-understood and understand others. The MDS indicated that the resident required total dependence on bed mobility, transfer, locomotion on and off unit, dressing, eating, toilet use, and personal hygiene. The MDS also indicated that the resident uses a wheelchair. The MDS further indicated that the resident had orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down). A review of Resident 121's Fall Risk Assessment, dated 10/10/2022, indicated that the resident was a high risk for fall. A review of Resident 121's Care Plan, revised on 11/11/2022, indicated that the resident was at risk for falls related to gait (manner of walking or moving on foot)/balance problems. The care plan indicated an intervention to promote a safe environment. During an observation and interview on 1/30/2023, at 10:40 a.m., with Registered Nurse 3 (RN 3), observed the resident's bed height was at working level (3 feet from the floor). RN 3 confirmed the observation and stated that she does not know how long the bed has been left on that height. RN 3 stated the height was not safe for the resident because the resident is at risk for falls. RN 3 stated the resident could fall, which could result in fractures. A review of the facility's recent policy and procedure titled Fall Risk Assessment, dated 11/28/2022, indicated that the facility will ensure the resident's environment minimizes hazards, and that each resident receives adequate supervision and assistance to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's recent policy and procedure titled Fall Management Program, dated 11/28/2022, to place bed in lowest position with brakes locked. A review of the facility's recent policy and procedure titled Resident Rooms and Environment, dated11/28/2022, indicated the purpose of the policy and procedure was to provide residents with a safe, clean, comfortable, and homelike environment. The resident will be provided with a bed of proper size and height for safety and convenience of the resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 34659 Based on observation, interview, and record review, the facility failed to follow professional standards of practice for urinary catheter (a tube placed in the body to drain and collect urine from the bladder) care for one of three sampled residents (Resident 104) investigated for the presence of a urinary catheter by failing to ensure irrigating a urinary catheter (process of flushing a urinary catheter with normal saline solution [salt water used in cleaning] to rid the urinary catheter of sediments [gritty particles in the urine]) was documented as being done. This deficient practice had the potential to result in a urinary tract infection (UTI, an infection in any part of the urinary system) for Resident 104. Findings: A review of Resident 104's Face Sheet (admission record) indicated the facility originally admitted the resident on 3/22/2022 with diagnoses including acute respiratory failure with hypoxia (a condition that occurs when the respiratory system cannot adequately provide oxygen to the body), stroke and quadriplegia (paralysis of all four limbs). A review of Resident 104's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/16/2022, indicated Resident 104 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 104 required total dependence (full staff performance every time during the entire seven-day assessment period) from one-person staff for toilet use, and personal hygiene. The MDS indicated Resident 104 had a urinary catheter. A review of Resident 104's Physician's Orders indicated the following: 1. Indwelling catheter: monitor every shift for signs and symptoms of possible urinary infection and call the doctor. Document 0 if no signs or symptoms. Document CU (change in urine) for change in character of urine such was change in urinary sediments every shift, dated 9/14/2022. 2. Indwelling catheter: flush urinary catheter with 50 cubic centimeters (cc., a unit of measuring liquid volume) normal saline every day as needed for sedimentation and cloudiness, dated 9/14/2022. A review of Resident 104's Care Plan for indwelling catheter (or urinary catheter), initiated 9/14/2022, indicated a goal that Resident 104 will have minimized risk for complications from indwelling catheter. The care plan indicated an intervention to observe urine odor, color, clarity (how clear the urine is), and amount as needed. During a concurrent interview and observation with Licensed Vocational Nurse 6 (LVN 6) on 1/30/2023 at 12:30 p.m., observed particles in Resident 104's urinary catheter tubing. LVN 6 stated the particles were sediments and Resident 104 had an order to irrigate the urinary catheter. LVN 6 stated she will irrigate the urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 104's Treatment Administration Record (TAR, a record for licensed nursing staff to document a resident's treatments) dated 1/1/2023 to 1/31/2023, indicated licensed nursing staff did not irrigate Resident 104's urinary catheter. The January 2023 TAR did not indicate licensed nursing staff documented sediments in Resident 104's catheter tubing During a concurrent interview and record review on 2/02/2023 at 9:52 a.m., Resident 104's January 2023 TAR was reviewed with LVN 6. LVN 6 stated there was no documentation of the sediments or irrigating the urinary catheter. LVN 6 stated she flushed Resident 104's urinary catheter but did not document the irrigation or the presence of sediments. LVN 6 stated she should have documented so that the other nurses would be aware in case there were other observations that would indicate a need to notify Resident 104's physician for a possible sign of infection. During an interview with the Director of Nurses (DON) on 2/02/2023 at 10:09 a.m., she stated LVN 6 should have documented on Resident 104's TAR, the presence of sediments and irrigating the urinary catheter. The DON stated this was important because it is part of monitoring for signs and symptoms of infection and the licensed nurses document also so they can communicate a resident's condition with other staff and Resident 104's physician to provide continuity of care. A review of the facility's policy and procedure titled, Care of Catheter, reviewed 11/28/2022, indicted when irrigation is necessary, intermittent irrigation (performing the task when needed) should be used and a physician's order is required. The policy and procedure indicated documentation of catheter care will be maintained in the resident's medical record.

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The Ellison John Transitional Care Center	43830 10th Street West Lancaster, CA 93534

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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** 38552 Based on observation, interview, and record review, the facility failed the following for three of seven sampled residents (Resident 106, Resident 8, and Resident 32: 1. Failed to ensure medication was not left at the bedside for Resident 106. This deficient practice had the potential to result in harm to Resident 106 from omitting the dose, double dosing later, and places other residents at risk due to sharing. 2. Failed to ensure blood pressure medications were held per ordered parameters by the physician for Resident 8. This deficient practice had the potential to result in unintended complications for Resident 8 related to the management of blood pressure such as hypotension (abnormally low blood pressure) and dizziness. 3. Failed to provide routine administration of medication accurately and safely for Resident 32 by failing to remove the Lidocaine External Patch (used to relieve pain) 5 percent (%, a number or ratio that can be expressed as a fraction of 100) on Resident 32's Left Upper Arm (LUA) on 1/30/2023 at 9 p.m. and failing to clarify Resident 32's order for Lidocaine External Patch 5% on 11/21/2022. These deficient practices had the potential to cause adverse effects of the medication on Resident 32. Findings: a. A review of Resident 106's Admission Record indicated the facility readmitted the resident on 1/7/2023 with diagnoses including pneumonia (an infection of the air sacs in one or both the lungs) and acute respiratory failure (condition that develops abruptly when the lungs cannot get enough oxygen into the blood) with hypoxia (a condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level). A review of Resident 106's History and Physical, dated 2/24/2022, indicated the resident had the capacity to understand and make decisions. A review of Resident 106's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/14/2023, indicated the resident's cognition (ability to think, understand, and reason) was intact. The MDS indicated Resident 106 required extensive assistance (resident involved in activity, staff provide weight-bearing support) from nursing staff with bed mobility (moving to and from lying positions, turning side to side, and positioning body while in bed), transfer (moving to or from bed, chair, wheelchair, standing position), dressing, toilet use and personal hygiene. (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 Resident 106's Physician Orders, dated 1/7/2023, indicated Sertraline HCl Oral Tablet 50 milligrams (mg, a unit of measure), give three tablets by mouth one time a day for depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) manifested by verbalization of sadness. A review of Resident 106's Self Administration of Medication Assessment, dated 1/8/2023, indicated the resident was not mentally able to administer own medications. During an observation on 1/30/2023 at 9:57 a.m., observed a blue pill inside a medication cup, placed on top of the resident's overbed table within Resident 106's reach. Observed Resident 106 asleep in bed. During a concurrent observation and interview on 1/30/2023 at 10:03 a.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 106's medication sitting on top of the overbed table. LVN 1 stated there should not be a medication left at the bedside. LVN 1 stated Resident 106 is asleep and will confirm with the licensed nurse. Observed LVN 1 shook the medicine cup and the blue pill freely moved inside the medicine cup. LVN 1 stated it seems Resident 106 had not taken it yet. During a concurrent observation and interview on 1/30/2023 at 10:05 a.m., LVN 1 stated the medication left at the bedside was Sertraline (an antidepressant). Observed LVN 1 administered Sertraline to Resident 106 and the resident was able to swallow the medication. During a concurrent interview, Resident 106 stated she does not know how long the medication had been sitting on the overbed table, but it must be one of her morning medications. During an interview on 1/30/2023 at 10:08 a.m., Resident 106 stated usually the licensed nurse hands the medication to her and she takes it while the licensed nurse is watching. Resident 106 stated the licensed nurse may have left it there while she was asleep. During an interview on 2/3/2023 at 3:47 p.m., the Director of Nursing (DON) stated there should not be any medication left at the bedside unless it was assessed that the resident may self administer medications. The DON stated for Resident 106 it was assessed that the licensed nurses will administer the medications for the resident's safety and accuracy. The DON stated when medications are left at the bedside the resident may missed that dose or another resident may accidentally ingest that medication which may cause the other resident to get sick. A review of the facility's policy and procedure titled, Medication - Administration, approved on 11/28/2022, indicated that it is the facility's policy that medications will not be left at the bedside. The procedure indicated that the licensed nurse would remain with the resident until the medicine is swallowed. 43323 b. A review of Resident 8's Admission Record indicated the facility admitted the resident on 1/27/2020, and readmitted on [DATE], with diagnoses of acute respiratory failure with hypoxia, dependence on respiratory ventilator (machine that pumps air into patients' airways when they are unable to breathe adequately on their own), and tachycardia (heart rate of more than 100 beats per minute). (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 Resident 8's MDS, dated [DATE], indicated Resident 8's cognitive skills (the act or process of knowing and perceiving) for daily decision making were severely impaired. The MDS further indicated Resident 8 was totally dependent on staff with two people assisting for bed mobility, transfer, dressing, toilet use, and personal hygiene. A review of Resident 8's physician's order, ordered on 11/25/2022, indicated an order to give metoprolol tartrate (medication used to treat high blood pressure) oral tablet 12.5 milligrams (mg, unit of measure) via gastrostomy tube (g-tube, feeding tube placed through the abdomen into the stomach) one time a day for tachycardia. Hold if systolic blood pressure (SBP - the top number, measures the force your heart exerts on the walls of your arteries each time it beats) is less than 110 or heart rate is less than 60 and to call Medical Doctor (MD) if SBP is less than 90 or heart rate is less than 60. During a concurrent interview and record review, on 2/2/2023 at 3:20 p.m., LVN 6 reviewed Resident 8's physician's order and stated that the resident is receiving metoprolol tartrate for tachycardia with ordered parameters to hold the medication if SBP is less than 110 or heart rate is less than 60. LVN 6 stated the licensed nurses check the vital signs including blood pressure and heart rate before giving a blood pressure medication and document in the resident's medical records. LVN 6 stated the licensed nurses would hold the medication if the SBP is below 110 or if the heart rate falls below 60 and document in the Medication Administration Record (MAR) that the medication was held with a rationale. LVN 6 reviewed Resident 8's MAR for January 2023 and confirmed the resident received metoprolol tartrate on the following dates as indicated by a check mark: 1/2/2023 at 9 a.m. for documented blood pressure of 106/74, 1/5/2023 at 9 a.m. for documented blood pressure of 102/65, 1/12/2023 at 9 a.m., for documented blood pressure of 104/72, and 1/23/2023 at 9 a.m. for documented blood pressure of 109/74. LVN 6 stated the licensed nurse should have held the medication on the specified dates since Resident 8's SBP was below 110 and stated the ordered parameters were not followed. LVN 6 stated administering blood pressure medications below the ordered parameters have the potential to further drop Resident 8's blood pressure and can lead to side effects that include lightheadedness and dizziness. During a concurrent interview and record review, on 2/3/2023 at 3 p.m., the Director of Nursing (DON) reviewed Resident 8's MAR for January 2023 and stated metoprolol tartrate was given on 1/2/2023, 1/5/2023, 1/12/2023, and 1/23/2023. The DON stated the medication should have been held for SBP below 110 following the ordered parameters. The DON further stated giving blood pressure medications below ordered parameters can result in resident having a hypotensive episode which can lead to resident possibly fainting. A review of the facility's policy and procedure titled, Medication - Administration, last reviewed on 11/28/2022, indicated medication will be administered per physician's order. 44376 c. A review of Resident 32's Admission Record indicated that the facility admitted the resident on 11/21/2022, with diagnoses including unspecified fracture of the upper end of left humerus (break in the bone in the upper arm), polyneuropathy (multiple peripheral nerves became damaged), and depression. (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 Resident 32's MDS, dated [DATE], indicated that the resident had severe cognitive impairment (problems with a person's inability to think, learn, remember, use judgement, and make decisions). The MDS indicated the Resident 32 required extensive assistance on bed mobility, dressing, and personal hygiene and total dependence on transfer, locomotion on and off unit, and toilet use. A review of Resident 32's Order Summary Report, dated 11/21/2022, indicated an order for Lidocaine External Patch 5% (Lidocaine). Apply to left upper arm topically (on the surface of the body) one time a day for pain management and remove per schedule. A review of Resident 32's Medication Administration Record, for 1/2023, indicated Lidocaine External Patch 5% (Lidocaine). Apply to left upper arm topically one time a day for pain management and remove per schedule. The MAR indicated that the patch will be removed at 8:59 a.m., and applied at 9 a.m. A review of Resident 32's Order Summary Report, dated 2/1/2023, at 6 p.m., indicated an order for Lidocaine Patch 5% (Lidocaine). Apply to left upper arm topically one time a day for pain management for 12 hours. Remove at 9 p.m. and remove per schedule. A review of Resident 32's Care Plan, revised on 11/23/2022, indicated a care plan of at risk for pain related to disease process, neuropathy (a nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body), left humerus fracture, and depression. During a concurrent observation and interview on 1/31/2023, at 8:15 a.m., at Station 1, together with LVN 7, Resident 32 stated she was going to shower today and stated she still had the other patch. Observed Resident 32 pulled down her left arm sleeve and showed the patch. Observed LVN 7 explained to Resident 32 that she will hold off on the lidocaine patch until after shower, the resident agreed. LVN 7 stated that a lidocaine patch dated 1/30/2023 was still on the resident's left upper arm. LVN 7 stated the Lidocaine patch should have been removed at 9 pm last night if it was applied at 9 am. LVN 7 stated Resident 32 could be on too much pain medication in her system. LVN 7 stated when the patch was left on longer than scheduled, it could cause irritation on the skin which could cause redness, swelling, and discomfort. During an interview on 2/3/2023, at 1 p.m., with the Pharmacist (PHARM) on the phone and Assistant Director of Nursing (ADON), the PHARM stated that she saw the order written on 11/22/2023 indicating Lidocaine External Patch 5% (Lidocaine) apply to left upper arm topically one time a day for pain management and remove per schedule. The PHARM stated that the order should have been clarified by the licensed nurses because lidocaine patches were supposed to remain on only for 12 hours. The PHARM stated that the order was discontinued on 2/1/2023. The pharmacist stated that she does not have any access to change the order in the Point Click Care (PCC, a cloud-based, integrated electronic healthcare record) because only staff in the facility has access to it. The PHARM stated that the lidocaine being sent to the facility was labeled with the correct order indicating Lidocaine External Patch 5% (Lidocaine) apply to left arm topically one time a day for pain management for 12 hours, remove at 2100 and remove per schedule. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 2/3/2023, at 1:10 p.m., the ADON stated that the MAR still had the previous order of lidocaine one time a day without the removal instruction at 9 p.m. and does not match the pharmacist lidocaine label which indicated every 12 hours applied at 9 a.m. and removed at 9 pm. The ADON stated that the staff should have clarified the order with the physician. ADON stated that the staff should have also removed the patch at 9 p.m. and not left the following day to prevent absorbing too much lidocaine. The deficient practice had the potential for medication error. A review of the facility's recent policy and procedure titled, Physician Orders, dated 11/28/2022, indicated the purpose of the policy and procedure was to ensure that all physician orders are complete and accurate. Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other healthcare disciplines will be transcribed onto the appropriate communication system for that discipline. A review of the facility's recent policy and procedure titled, Specific Medication Administration Procedures: Transdermal Drug Delivery System (Patch) Application), dated 11/28/2022, indicated to remove old patch from body. Fold in half with adhesive sides together. Discard according to facility policy. A review of the facility's recent policy and procedure titled, Medication- Administration, dated 11/28/2022, indicated medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner. Medications will be administered per physician's order.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility failed to manage the resident's medication regimen appropriately for three of seven sampled residents (Resident 121, 114 and 98 by: 1. Failing to act upon the facility's pharmacy consultant's recommendation to clarify from the physician the intended length of therapy of Enoxaparin (Lovenox, a blood thinner) for Resident 121. 2. a. Failing to act upon the facility's pharmacy consultant's recommendation to clarify from the physician the length of therapy for Lovenox and the instructions for use of Chlorhexidine Gluconate (Peridex) (helps reduce the number of germs in your mouth or on your skin) on the Medication Administration Record for Resident 114. b. Failing to act upon the facility's pharmacy consultant's recommendation to clarify from the physician the intended length of therapy for Resident 114's PRN order for Diphenoxylate -Atropine (Lomotil) (a prescription medicine used to treat the symptoms of diarrhea) if needed (PRN), enoxaparin (Lovenox), and Ondansetron (Zofran) (a drug used to prevent nausea and vomiting) 3. Failing to act upon the facility's pharmacy consultant's recommendation to clarify from the physician if a dose change was warranted for Resident 98's use of Citalopram (medication to treat depression) and Quetiapine (medication to treat psychosis [a severe mental disorder in which a person loses the ability to recognize reality or relate to others]). These deficient practices had the potential to cause adverse (unwanted) side effects from the continued use of these medications. Findings: 1. A review of Resident 121's Admission Record indicated that the facility admitted the resident on 10/10/2022 and readmitted the resident on 11/7/2022, with diagnoses including chronic respiratory failure (is a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the heart] fire rapidly at the same time), and gastro-esophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting the mouth and stomach). A review of Resident 121's History and Physical (H&P), dated 11/10/2022, indicated that the resident had the capacity to understand and make decisions. A review of Resident 121's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/14/2022, indicated that the resident had the ability to make self-understood and understand others. A review of the facility's Consultant Pharmacist's Medication Regimen Review, dated 11/1/2022 to 11/30/2022, indicated to clarify the intended length of therapy for the Enoxaparin (Lovenox) order. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 121's Order Summary Report, dated 11/7/2022, indicated an order for enoxaparin sodium injection solution prefilled syringe 40 milligrams (mg, a unit of mass or weight)/ 0.4 milliliter (ml, a unit of volume) (enoxaparin sodium) Inject 40 mg subcutaneously (situated or lying under the skin) one time a day for Deep Vein Thrombosis (DVT, a medical condition that occurs when a blood clot forms in a deep vein) prophylaxis (PPX, an attempt to prevent disease). Rotate injection site (a method to ensure repeated injections are not administered in the same area). During a concurrent record review and interview on 2/2/2023, at 10:22 a.m., Resident 121's medical record was reviewed with the ADON. The ADON stated that there was no notation on the medical record that the pharmacist recommendation was acted upon. The ADON stated that the resident is at risk for harm when their needs are not communicated to the physician and other healthcare staff. 2. A review of Resident 114's Admission Record indicated that the facility admitted the resident on 7/13/2022 and readmitted the resident on 12/7/2022, with diagnoses including acute respiratory failure, anoxic brain damage (caused by a complete lack of oxygen to the brain, which results in the death of brain cells), gastro-esophageal reflux disease. A review of Resident 114's MDS, dated [DATE], indicated that the resident rarely/never had the ability to make self-understood and sometimes had the ability to understand others. The MDS indicated that the resident required total dependence on bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. A review of the facility's Consultant Pharmacist's Recommendations created between 10/1/2022 and 10/31/2022, indicated: -Please clarify the intended length of therapy for the Enoxaparin (Lovenox) order. -Please indicate whether to Swish & Swallow OR Swish and Spit Out to the order for Chlorhexidine Gluconate (Peridex) 0/12% on the Medication Administration Record. A review of Resident 114's Order Summary Report, indicated an order for: -Enoxaparin Sodium Injection Solution Prefilled Syringe 40 mg/0.4ml (enoxaparin sodium), inject 0.4 milliliter subcutaneously one time a day for DVT PPX rotate injection sites, with order date of 12/8/2022. -Diphenoxylate-Atropine Oral Tablet 2.5-0.025 mg (Diphenoxylate w/ Atropine). Give 2 tablet via gastrostomy tube (G-tube, a tube inserted through the wall of the abdomen directly into the stomach) every 6 hours as needed for Diarrhea, with order date of 12/7/2022. -Ondansetron HCl Oral Tablet 4 mg (Ondansetron HCl). Give 1 tablet via G-tube every 24 hours as needed for nausea/vomiting, with order date of 12/7/2022. During a concurrent record review and interview on 2/2/2023, at 10:42 a.m., reviewed Resident 114's medical record with the ADON. The ADON stated that the pharmacist's recommendations were not acted upon. The ADON stated that there was no follow-up done to clarify the order for length of therapy for Lovenox Lomotil PRN, Zofran, and method of administration for Chlorhexidine. The ADON stated that the deficient practice placed the resident at risk for adverse consequences and side effects. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/2/2023, at 2:50 p.m., with the DON, the DON stated that the Chlorhexidine, Lomotil, Lovenox, and Zofran pharmacy recommendations to indicate length of therapy were not acted upon. The DON stated that the deficient practice had to potential for unnecessary medications and adverse side effects to residents. 3. A review of Resident 98's Admission Record indicated that the facility admitted the resident on 9/24/2021 and readmitted the resident on 12/10/2022, with diagnoses including acute respiratory failure, psychosis not due to a substance or unknown physiological condition, and anxiety disorder. A review of Resident 98's MDS, dated [DATE], indicated that the resident rarely had the ability to make self-understood and understand others. The MDS further indicated that the resident was on antipsychotic (medication used to treat psychosis) and antidepressant medications (medication used to treat depression). A review of the facility's Consultant Pharmacist's Medication Regimen review between 11/1/2022 and 11/30/2022, indicated: -Patient has been on Citalopram 5mg QHS for Depression since 8/21/2022. Do you feel a dose change is warranted at this time? -Patient has been on Quetiapine 25mg QHS for Psychosis since 8/24/2022. Do you feel dose change is warranted at this time? A review of Resident 98's Order Summary Report indicated an order for: -Quetiapine Fumarate Oral Tablet 25 mg (Quetiapine Fumarate) Give 1 tablet via g-tube at bedtime for psychosis monitor for behavior manifestation of excessive agitation as evidenced by pulling out life sustaining tubes, with order date of 8/24/2022. -Citalopram Hydrobromide Oral Tablet (Citalopram Hydrobromide) give 5 mg via g-tube at bedtime for depression monitor for behavior manifestation of difficulty falling asleep, with order date of 8/21/2022. During a concurrent record review and interview on 2/2/2023, at 11:07 a.m., reviewed Resident 98's medical record with ADON. The ADON stated that she did not see any notes on the resident's medical record addressing the dosage change for Citalopram and Seroquel. The ADON stated that the deficient practice had the potential for residents to have unnecessary medications. During an interview on 2/2/2023, at 2:40 p.m., with the Director of Nursing (DON), the DON was not able to provide any evidence indicating that the pharmacist's recommendations for Citalopram and Seroquel were acted upon. The DON stated that failure to act upon the consultant pharmacist's recommendations on medications could potentially cause unnecessary medications to residents and possibly adverse drug reactions. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's recent policy and procedure titled Drug Regimen Review, dated 11/28/2022, indicated the attending physician will respond to any irregularities reported by the pharmacist by reviewing the irregularities and documenting in the resident's medical record that the irregularity has been reviewed, and what, if any, action has been taken to address it. If no action has been taken, the attending physician must document his/her rationale. Documentation by the Attending Physician must occur within 30 days of issuance of the pharmacist's report, unless the irregularity is an emergent issue requiring immediate action. The Medical Director and DON will also review the pharmacist's report if any irregularities are identified. The DON is responsible for following up with the Attending Physician, as indicated.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 44376 Based on interview and record review the facility failed to ensure a resident was free from unnecessary drugs for one of seven sampled residents (Resident 139) by failing to adequately monitor for the adverse effects of Lovenox (prevent blood from clotting) use on multiple occasions. This deficient practice had the potential for adverse (unwanted) reactions including bleeding and bruising. Findings: A review of Resident 139's Admission Record indicated that the facility admitted the resident on 12/30/2022, with diagnoses including acute respiratory failure (a condition that happens when your lungs cannot get enough oxygen into your blood or remove enough carbon dioxide), cerebral infarction (occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it), gastro-esophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting the mouth and stomach). A review of Resident 139's History and Physical (H&P), dated 1/12/2023, indicated that the resident had the capacity to understand and make decisions. A review of Resident 139's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/4/2023, indicated that the resident sometimes had the ability to make self-understood and understand others. The MDS also indicated that the resident was on an anticoagulant (a substance that prevents and treats blood clots in the blood vessels and the heart). A review of Resident 139's Order Summary Report indicated an order for: -Enoxaparin Sodium Injection Solution Prefilled Syringe 40 milligrams (mg, a unit of mass or weight)/0.4 milliliters (ml, a unit of volume) (enoxaparin sodium) (an anticoagulant medicine) inject 0.4 ml subcutaneously (sq, beneath or under the layers of the skin) one time a day for Deep Vein Thrombosis (DVT, a medical condition that occurs when a blood clot forms in a deep vein) Prophylaxis (PPX, an attempt to prevent disease) with order date of 1/1/2023. -Enoxaparin: Monitor for signs and symptoms of bleeding (abnormal or unexplained bruising, petechiae [pinpoint, unraised, round red spots under the skin caused by bleeding], internal bleeding, nosebleeds, bleeding gums, abnormal bleeding) by (+) YES or (-) NO. Notify MD if (+) every shift, with order date of 12/31/2022. A review of the Medication Administration Record (MAR) for 1/2023, indicated that on 1/11/2023, 1/23/2023, and 1/24/2023 day shift (7 a.m. to 3 p.m.) Enoxaparin: Monitor for signs and symptoms of bleeding every shift was left blank. A review of Resident 139's Care Plan, dated 1/3/2023, indicated a care plan for resident at risk for bleeding, bruising, and or skin discoloration related to anticoagulant therapy. The care plan indicated an intervention to administer medications as ordered and monitor for side effects. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 2/2/2023, at 10:13 a.m., Resident 139's MAR was reviewed with the Assistant Director of Nursing (ADON). The ADON stated that the staff should have initialed/signed the monitoring log on the use of enoxaparin on 1/11/2023, 1/23/2023, and 1/24/2023 in the MAR to indicate that it was done. The ADON further stated that if the monitoring sheet was left blank it means that it was not done. The ADON further stated that the deficient practice had the potential to place the residents at risk for adverse consequences. A review of the facility's recent policy and procedure titled Anticoagulant Therapy, dated 11/28/2022, indicated the purpose of the policy was to ensure that anticoagulant therapy was safely and effectively administered. The facility will monitor residents receiving anticoagulant therapy. Instruct the resident and family regarding the side effects and adverse drug effects of anticoagulant therapy. Document the decision in the medical record. A review of the facility's recent policy and procedure titled Documentation- Nursing, revised 11/28/2022, indicated that medication administration records and treatment administration records are completed with each medication or treatment completed. Documentation will be completed by the end of the assigned shift.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on observation, interview, and record review the facility licensed staff failed to follow their policy and procedures by failing to label four multi-use medication containers with open dates (date written on a medication when it was first opened for use) for one out of five medication carts reviewed (Station 2 Cart 2) during facility task Medication Storage and Labeling. The deficient practice had the potential to result in nursing staff administering low potent (effect) or expired medications. a. A review of Resident 12's Admission Record indicated that the facility admitted the resident on 2/20/2018 and readmitted the resident on 11/9/2021 with diagnoses including cord compression (compression of nerve bundle in lower spine), spinal stenosis (happens when the spaces in the spine narrow and create pressure on the spinal cord and nerve roots), and polyarthritis (inflammation or swelling of five or more joints at the same time). A review of Resident 12's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/1/2023, indicated that the resident had the ability to make self-understood and understand others. The MDS indicated that the resident was totally dependent on personal hygiene. A review of Resident 12's Order Summary Report, dated 10/13/2022, indicated an order for Debrox Otic (relating to the ear) Solution (Carbamide Peroxide [Otic]) instill (the dispensation of a sterile ophthalmic medication into the eye) 2 drops in both ears one time a day for ear wax build up. During a concurrent observation and interview on 1/30/2023, at 9:35 a.m., in Station 2 Cart 2, observed with Licensed Vocational Nurse 8 (LVN 8) Resident 12's Debrox Otic Solution without an opened date. LVN 8 stated that the medication should have been dated with an open date to prevent administering expired medications to residents. During an interview on 2/3/2023 with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that that all multi-use medications should be dated once opened. LVN 1 stated that the Debrox Otic Solution should be discarded after the treatment usually within 3-5 days to prevent administering expired medication or less potent medication. b. A review of Resident 111's Admission Record, indicated that the facility admitted the resident on 5/6/2022, with diagnoses including non-ST elevation myocardial infarction (a type of heart attack that usually happens when the heart's need for oxygen cannot be met), dysphagia (difficulty swallowing), and gastro-esophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach). A review of Resident 111's MDS, dated [DATE], indicated that the resident had the ability to make self-understood and understand others. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 111's Order Summary Report, indicated an order for nitroglycerin tablet sublingual (under the tongue). Give 1 tablet sublingually every 5 minutes as needed for chest pain. Give 1 tablet sublingual every 5 minutes interval, call MD if no relief after third dose, with an order date of 5/6/2022. During a concurrent observation and interview on 1/30/2023, at 9:53 a.m., with LVN 8, observed with LVN 8 Resident 111's nitroglycerin 0.4 mg tab with no opened date. LVN 8 stated that the medication should have been dated with an open date to prevent administering expired medications to residents. During an interview on 2/3/2023 with LVN 1, LVN 1 stated that that all multi-use medications should be dated once opened. LVN 1 stated that the nitroglycerine sublingual should be discarded once opened after 30 days to prevent administering expired medication or less potent medication. c. A review of Resident 17's Admission Record indicated that the facility admitted the resident on 9/2/2021 and readmitted the resident on 6/15/2022, with diagnoses including pneumonia (a severe inflammation of the lungs in which the tiny air sacs are filled with fluid), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements such as shaking, stiffness etc.), and dysphagia. A review of Resident 17's MDS, dated [DATE], indicated that the resident sometimes had the ability to make self-understood and understand others. A review of Resident 17's Order Summary Report, dated 1/10/2023, indicated an order for Scopolamine transdermal patch 72 Hour 1 mg/3 days (Scopolamine). Apply 1 patch transdermal (attaches to the skin) every 72 hours for secretions and remove per schedule. During a concurrent observation and interview on 1/30/2023, at 9:53 a.m., with LVN 8, Observed with LVN 8 Resident 17's packet of scopolamine patch with no opened date. The packet of scopolamine patch contained more than one patch in a packet. LVN 8 stated that the medication should have been dated with an open date to prevent administering expired medications to residents. During an interview on 2/3/2023 with LVN 1, LVN 1 stated that that all multi-use medications should be dated once opened. LVN stated that scopolamine patch, once opened should be discarded in 30 days to prevent administering expired medication or less potent medication. d. A review of Resident 21's Admission Record indicated that the facility admitted the resident on 7/29/2022 and readmitted the resident on 11/11/2022, with diagnoses including chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), emphysema (a disorder affecting the tiny air sacs of the lungs), and acute respiratory distress (occurs when fluid builds up in the tiny, elastic air sacs in the lungs). A review of Resident 21's MDS, dated [DATE], indicated that the resident had the ability to make self-understood and understand others. The MDS also indicated that the resident was on oxygen therapy (a treatment that provides with supplemental, or extra oxygen). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 21's Order Summary Report, dated 8/25/2022, indicated an order for ipratropium-albuterol inhalation solution 0.5-2.5 mg/3 ml. (used to prevent shortness of breath, coughing, and chest tightness) Inhale orally every 6 hours as needed for shortness of breath/wheezing (a high-pitched whistling sound made while breathing). During a concurrent observation and interview on 1/30/2023, at 9:53 a.m., with LVN 8, Observed with LVN 8 Resident 21's ipratropium/ albuterol inhalation packet with no opened date. LVN 8 stated that the medication should have been dated with an open date to prevent administering expired medications to residents. During an interview on 2/2/2023, at 10:42 a.m., with ADON, ADON stated that stated that multi-use medications should be labeled with an open date to prevent dispensing expired medications. A review of the facility's recent policy and procedure titled Specific Medication Administration Procedures: Administration Procedures for All Medications, dated 11/28/2022, indicated to check the expiration date on package/container before administering any medication. When opening a multi-dose container, place the date on the container. A review of the facility's recent policy and procedure titled Preparation and General Guidelines: Vials and Ampules of Injectable Medications, dated 11/28/2022, indicated the date opened and the initials of the first person to use the vial are recorded on multidose vials on the vial label or an accessory label affixed for that purpose). The solution in multidose vials (MDV) is inspected prior to each use for unusual cloudiness, precipitation, or foreign bodies. The rubber stopper is inspected for deterioration. If a MDV is opened and does not indicate the date opened, the product should not be used and should be discarded accordingly to the facility's policy. Medication in multidose vials may be used (until the manufacturer's expiration date/for length of time allowed by state/according to facility policy/for thirty days) if inspection reveals no problems during that time.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to maintain medical records on each resident that are complete and accurately documented for two of eight (Resident 104 and Resident 114) residents by failing to: 1. Ensure licensed nurses accurately documented on the respiratory treatment administration record (RTAR, a form in which respiratory medications are documented after being given to a resident) for Resident 104. 2. Ensure licensed nurses document every shift on the Medication Administration Record (MAR) monitoring for adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) related to the use of lorazepam (a prescription medicine used to treat the symptoms of anxiety disorders) and monitoring for target behavior (behavior identified to be changed) and adverse effects related to the use of Zoloft (medication used to treat depression and panic attacks) for Resident 114. Findings: 1. A review of Resident 104's Admission Record indicated the facility originally admitted the resident on 3/22/2022 with diagnoses that included acute respiratory failure with hypoxia (a condition that occurs when the respiratory system cannot adequately provide oxygen to the body). A review of Resident 104's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/16/2022, indicated Resident 104 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 104 was totally dependent (full staff performance every time during the entire seven-day assessment period) from one-person staff for dressing, eating, toilet use, and personal hygiene. A review of Resident 104's Physician's Orders, dated 9/14/2022, indicated an order for ipratropium-albuterol (a medication inhaled that opens the airway to make breathing easier) solution 0.5-2.5 (3) milligram per 3 milliliters (mg/ml, units of measure) via tracheostomy (trach, an opening in the windpipe so that one can breathe) every six hours for shortness of breath; notify the physician if the heart rate increases to 10 or above from heart rate accessed before giving treatment. A review of Resident 104's RTAR, for the month of January 2023, indicated blank entries on 1/03/2023 at 7 p. m., 1/04/2023 at 7 p.m., 1/20/2023 at 1 p.m., 1/25/2023 at 7 p.m., and 1/26/2023 at 1 a.m. for the medication ipratropium-albuterol 3 mg/3 ml. During a phone interview with Registered Nurse 1 (RN 1) on 2/02/2023 at 1:46 p.m., she stated she gave the ipratropium-albuterol to Resident 104 on 1/04/2023 and 1/25/2023. RN 1 stated she was unable to sign the RTAR on the medication cart computer and had to document on another computer. RN 1 stated the computer might not have saved the documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN 3 on 2/02/2023 at 4:10 p.m., she stated she gave Resident 104 the 1/20/2023 1 p.m. ipratropium-albuterol medication on 1/20/2023 but something may have happened when she was signing the RTAR that did not save the documentation in the computer. During an interview with RN 4 on 2/02/23 at 4:49 p.m., she stated she gave Resident 104 the ipratropium-albuterol medication on 1/03/2023 at 7 p.m. RN 3 stated she had to sign the medication on another computer other than the medication cart the medication is taken from. RN 3 stated she did remember giving the medication that evening. During a concurrent interview and record review, on 2/02/2023 at 5 p.m., the Director of Nursing (DON) stated the licensed nurses administered the ipratropium-albuterol medication on the dates with the blank spaces in January 2023 but due to a computer issue the documentation was not saved correctly. A review of the facility's policy and procedure titled Documentation-Nursing, reviewed 11/28/2022, the medication administration records and treatment administration records are to be completed with each medication or treatment completed. 44376 2. A review of Resident 114's Admission Record indicated that the facility admitted the resident on 7/13/2022 and was readmitted on [DATE], with diagnoses of acute respiratory failure (a condition that happens when the lungs cannot get enough oxygen into the body or remove enough carbon dioxide), depression, and anxiety. A review of Resident 114's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/6/2023, indicated that the resident rarely/never had the ability to make self-understood and understand others. The MDS indicated that the resident had severely impaired cognitive skills (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life) for daily decision making. The MDS further indicated that the resident was on antianxiety (medication to treat anxiety) and antidepressant (medication to treat depression) medications. A review of Resident 114's Order Summary Report indicated an order for: -Zoloft oral tablet 25 milligram (mg, a unit of mass or weight) (Sertraline HCL), give 1 tablet via gastrostomy tube (g-tube, a tube inserted through the wall of the abdomen directly into the stomach) one time a day for depression monitor for behavior of sad affect, with order date of 12/8/2022. -Zoloft: Monitor side effect of anti-depressant agent every shift. Chart 0 for none or use 1st letter HDTAS H=headache; D=dizziness; T=tremors; D= dry mouth; A=anorexia; D= diarrhea; S=sweating, with order date of 1/6/2023. -Zoloft: Monitor episodes of depression monitor for behavior of sad affect every shift, with order date of 1/6/2023. - Lorazepam oral tablet 1mg (lorazepam), give 1 tablet via g-tube every 8 hours as needed for anxiety monitor for behavior excessive restlessness until 2/9/2023, with order date of 1/9/2023. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ativan: Monitor side effects of anti-anxiety agent every shift. Chart 0 for none or use 1st letters SDAP. S= sedation; D=dizziness; A=ataxia; P=paradoxical excitation, with order date of 12/7/2022. A review of Resident 114's Care Plan indicated: -Resident on lorazepam related to anxiety manifested by behaviors of excessive restlessness, initiated on 12/12/2022. The care plan indicated an intervention to monitor and document side effects and effectiveness of the medication. -Resident on Zoloft related to depression manifested by sad affect, initiated on 12/12/2022. The care plan indicated an intervention to monitor side effects of anti-depressant agent every shift and monitor and report to MD if necessary for side effects and adverse reactions. A review of Resident 114's Medication Administration Record (MAR) for 1/2023 indicated: - Missing entry on 1/11/2023 day shift for Ativan: monitoring for side effects of anti-anxiety agent every shift. - Missing entries on 1/11/2023 day shift Zoloft: Monitor episodes of depression monitor for behavior of sad affect every shift and 1/15/2023 night shift. - Missing entry on 1/11/2023 day shift Zoloft: Monitor side effects of anti-depressant agent every shift. During a concurrent interview and record review on 2/2/2023, at 10:42 a.m., reviewed Resident 114's MAR with the Assistant Director of Nursing (ADON), the ADON stated that there were missing entries on monitoring for side effects and behavior for use of Ativan and Zoloft in the MAR of the resident. The ADON stated that if it is not documented, it was not done. The ADON stated that the deficient practice had the potential for adverse effects not identified on the resident. A review of the facility's recent policy and procedure titled Psychotherapeutic Drug Management, dated 11/28/2022, indicated that the attending medical practitioner will review the current drug regimen monthly and determine if the resident should remain on the same dose or an adjustment should be made. The attending physician will respond to any irregularities reported by the pharmacist as described in section VI (D) by reviewing the irregularities and documenting in the resident's medical record that the irregularity has been reviewed, and what, if any, action has been taken to address it. If no action has been taken, the attending physician must document his/her rationale. Documentation by the Attending Physician must occur within 30 days of issuance of the pharmacists' report, unless the irregularity is an emergent issue requiring immediate action. Will monitor psychotropic drug use daily noting any adverse effects (i.e., EPS, Tardive dyskinesia, excessive dose, or distressed behavior). Monitoring should also include evaluation of the effectiveness of non-pharmacological approaches prior to administering PRN medications. Reviews the use of the medication with the physician and the interdisciplinary team at least quarterly to determine the continued presence or target behaviors and or the presence of any adverse effects of the medication use. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's recent policy and procedure titled Documentation- Nursing, revised 11/28/2022, indicated that medication administration records and treatment administration records are completed with each medication or treatment completed. Documentation will be completed by the end of the assigned shift.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 43988 Based on interview, and record review, the facility failed to ensure a resident who was receiving hospice services (a program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill) had a current hospice certification from the physician for one of one sampled resident (Resident 94) reviewed for hospice care. This deficient practice had the potential to result in a delay or lack of coordination in delivery of hospice care and services to Resident 92. Findings: A review of Resident 94's Admission Record indicated the facility admitted the resident on 11/12/2021 and readmitted the resident on 3/13/2022 with diagnoses type 2 diabetes mellitus (a long-term medical condition in which your body doesn't use insulin [a hormone that helps regulate the amount of sugar, or glucose, in the blood] properly, resulting in unusual blood sugar levels), quadriplegia (a form of paralysis [the loss of ability to move some or all of your body] that affects all four limbs). A review of Resident 94's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 12/1/2022, indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required two-person total assistance with transfers, and one-person total assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). A review of Resident 94's Order Summary Report indicated a physician's order dated 8/17/2022 to admit resident to hospice service (a type of care and philosophy of care that focuses on the palliation of a chronically ill, terminally ill or seriously ill patient's pain and symptoms, and attending to their emotional and spiritual needs) under routine level of care with diagnosis of quadriplegia and cervical spinal stenosis. A review of Resident 94's Physician's Certification for Hospice Benefit (report from the physician justifying the need for hospice services) dated 8/4/2022, indicated the resident was terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. It also indicated the certification period was from 8/4/2022 to 11/1/2022. During a concurrent interview and record review on 2/2/2023 at 9:26 a.m., reviewed Resident 94's Physician's Recertification for Hospice Benefit form dated 8/4/2022 to 11/1/2022 with the Social Services Director (SSD). The SSD stated the recertification form was not discussed with the hospice representative during the quarterly Interdisciplinary Team Meeting (IDT - a group of professionals that works residents and/or representatives to plan coordinate, coordinate and deliver personalized health care). The SSD stated that the form should have been followed up with the hospice representative, updated and placed in the chart timely to prevent delay in providing the hospice services Resident 94 needed. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/2/2023 at 10:04 a.m., the Director of Nursing (DON) stated that the SSD was responsible in coordinating with the hospice representative in ensuring that the resident that has a current hospice certification in the medical record. The DON also stated it was important to have a current hospice certification in order to prevent delay in implementing Resident 94's plan of care and providing necessary care and services. A review of the Hospice Agreement signed by the facility and Urgent Help Hospice (UHH) with effective date 8/3/2022, indicated the SSD as one of the facility's contact persons. The agreement indicated the hospice shall provide the physician certification and recertification of the terminal illness specific to each resident. The agreement also indicated a member of the facility's IDT was responsible for following the physician certification and recertification of the terminal illness specific to each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ellison John Transitional Care Center	43830 10th Street West Lancaster, CA 93534

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43988 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program for two of nine sampled residents (Resident 16 and Resident 445) by: 1. Failing to ensure Resident 16's nebulizer (a small machine that turns liquid medicine into a mist) tubing was changed per facility policy and procedure. 2. Failing to ensure Resident 445's urinal (a container for collecting urine) was labeled with the resident's name, date, and room number. These deficient practices had the potential for contamination of residents' equipment and placed the residents at risk for infection. Findings: a. A review of Resident 16's Admission Record indicated the facility admitted the resident on 11/22/2017 and readmitted the resident on 10/27/2018 with diagnoses chronic obstructive pulmonary disease (COPD - a condition that damages the lungs in ways that make it hard to breathe), dementia (a condition affecting memory, thinking and social abilities that interferes with daily functioning), Parkinson's disease (a disorder of the central nervous system [the body's processing center which controls most of the functions of the body] that affects movement, often including tremors [disorder that causes involuntary and rhythmic shaking]. A review of Resident 16's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 1/10/2023, indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision with eating, one-person extensive assistance with bed mobility, dressing, toilet use, and personal hygiene, two-person extensive assistance with transfers, and one-person total assistance with bathing. During an observation on 1/30/2023 at 10:15 a.m., observed nebulizer and tubing inside a plastic bag. The tubing and the plastic bag were dated 1/18/2023. During a concurrent observation and interview on 1/30/2023 at 10:20 a.m., with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated verified that the date on the nebulizer tubing was 1/18/2023. LVN 5 stated all tubings are changed weekly per facility policy. LVN 5 stated that the nebulizer tubing should have been changed on 1/25/2023 for infection control. During an interview on 1/30/2023 at 10:48 a.m., the Infection Preventionist (IP) stated that the date on the nebulizer tubing was 1/18/2023. The IP stated the tubing should have been changed weekly per facility policy. The IP stated it was important to change the tubings weekly per facility policy to prevent contamination of resident equipment and spread of infection. During a concurrent interview and record review on 2/3/2023 at12:37 p.m., the facility's policy and procedure titled, Small Volume Nebulizer was reviewed with the IP. The IP stated that the policy indicated to change the nebulizer tubing to prevent bacterial contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During another concurrent interview and record review on 2/3/2023 at 12:53 p.m., the facility's policy and procedure titled, Oxygen Administration was reviewed with the IP. The IP verified that the policy indicated all oxygen tubings, masks, and cannulas will be changed weekly and when visibly soiled. The IP stated that the facility uses this policy and procedure when changing nebulizer tubings. 44376 b. A review of Resident 445's Admission Record, indicated that the facility admitted the resident on 1/25/2023, with diagnoses including peritoneal abscess (collection of pus or infected material and is usually due to localized infection inside the abdomen), intra-abdominal (situated in the abdomen) and pelvic swelling, mass and lump, and severe sepsis without septic shock (life-threatening organ dysfunction due to a dysregulated host response to infection). A review of Resident 445's History and Physical (H&P), dated 1/28/2023, indicated that the resident has the capacity to understand and make decisions. A review of Resident 445's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/1/2023, indicated that the resident had the ability to make self-understood and understand others. The MDS indicated that the resident required extensive assistance on toilet use and personal hygiene. The MDS also indicated that the resident was occasionally incontinent of urine and stool (feces). A review of Resident 445's Care Plan, dated 1/30/2023, indicated a care plan for infection of the colon (longest part of the large intestine): necrotic (death of body tissue) mass colon. The care plan had a goal of the resident will be free from complications related to infection. The care plan included an intervention to maintain universal precautions (an approach to infection control to treat all human blood and body fluids as if they contain bloodborne infections) when providing resident care. During an observation and interview on 1/30/2023, at 11:13 a.m., with Registered Nurse 3 (RN 3), observed two bottles of urinals not labeled hanging on the upper left side rail of the resident's bed. RN 3 stated that the staff should have labeled the urinal bottles with the room number and date it was provided. RN 3 further stated that they were supposed to change the urinal bottles weekly. RN 3 stated that it was important to label the urinal bottles with the room number and the date to prevent mixing the bottles with another resident which could cause infection. During an interview on 1/30/2023, at 1:29 p.m., with the Infection Preventionist (IP), the IP stated that the staff should labeled the urinal with the resident's name and room number to prevent spread of infection. A review of the facility's recent policy and procedure titled Urinal and Bedpan - Offering and Removing, dated 11/28/2022, indicated to observe (standard) universal precautions or other infection control standards as indicated.