STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555677	A. BUILDING _____ B. WING _____	02/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE HEALTHCARE & WELLNESS CENTRE, LP	11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification Survey and facility reported incident (FRI) investigation. Facility Reported Incident Intake No: CA00573323- substantiated with no regulatory violation. Representing the Department of Public Health: Surveyor ID: 34396, RN, HFEN Surveyor ID: 36394, RN, HFEN Surveyor ID: 38551, RN, HFEN Total Population: 75 Sampled Size: 18 Randomly selected Residents: 7	F 000	RECEIVED MAR 14 2018 By _____ 3/15/18 Preparation and/or execution of this Plan of Correction does not constitute admission by the Provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it's required by the provision of Health and Safety Code Section 1280 and 42 C.F.R. 483. Please accept this POC as our credible allegation of compliance.	
F 558 SS=E	Highest Scope and Severity: E Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the emergency crash cart (a cart that contained equipment used during an emergency procedure) was fully equipped with emergency medical supplies.	F 558	**F-558** **I. Corrective Action/s:** The IM, SQ and pulse oximetry were immediately placed at the crash cart on 02/19/18.. **II. How to Identify Other Residents:** No other resident is affected by this practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X8) DATE

[signature] | Administration | 3/15/18

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

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This deficient practice had the potential to delay treatment and could result in harm to the residents in the facility.

Findings:

On 2/19/18 at 7:27 a.m., during a concurrent observation, interview and review of the contents inside of an unlocked emergency crash cart with a licensed vocational nurse (LVN 1), there was no intramuscular ([IM] technique used to administer medication deep into the muscles) and subcutaneous ([SQ] technique used to administer medication under the skin) syringes. In addition, the crash cart did not have an oximeter ([pulse ox], an instrument used to measure the amount of oxygen in a resident's blood). LVN 1 stated she checked the crash cart on 2/19/18 at 12 a.m., but failed to identify the missing items and should have crossed checked properly before signing that all the items listed were in the cart. LVN 1 stated the pulse oximeter was in the nurses' medication cart and not the crash cart. A review of the crash cart checklist dated 2/19/18 indicated the crash cart was checked, verified, and signed off, by LVN 1 during the 11-7 pm shift. However, the inventory checklist was inaccurate and did not indicate the specific number of items contained inside the cart.

On 2/19/18 at 4 p.m., during an interview the director of nursing (DON) stated a pulse ox was supposed to be in the crash cart and LVN 1 just placed one including the missing syringes in the crash cart. According to the DON, a pulse ox

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F 558	Continued From page 2 was a part of the crash cart equipment that should be present at all times. A review of the facility's policy and procedures with a revision date of 1/1/12, titled "Emergency Medical Supplies" indicated its purpose was to protect the health and safety of residents by ensuring the facility maintained sufficient emergency medical supplies and equipment to meet the needs of residents at all times.	F 558		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F 578		

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legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure nine of 27 sampled residents (10, 47, 55, 59, 69, 76, 77, 78 and 92,) had specific choices and treatments communicated through an Advance Directive by not having incomplete Physician Orders for Life-Sustaining Treatment ([POLST] a physician order that outlines the plan of care regarding a resident's life sustaining choices).

This deficient practice had the potential for the residents not be given the right to accept or refuse specific medical treatments and have those options honored.

Findings:

a. A review of the clinical records indicated Resident 10 was re-admitted on February 8,

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F 578	Continued From page 4	F 578		

2017, with diagnoses that included right sided hemiplegia (a weakness on the right of side of the body).

The Minimum Data Set (MDS), a standardized assessment and care-screening tool), dated January 26, 2018 indicated Resident 10 usually had the ability to make self-understood and usually understood others. The resident required extensive to total assistance from staff with all her activities of daily living.

During record review on February 18, 2018 at 4:00 p.m., no indication of Advance Directive was found in Resident 10's clinical records.

b. A review of the clinical records indicated Resident 47 was re-admitted on January 16, 2018, with diagnoses that included complete paraplegia (paralysis of the legs and lower body).

The Minimum Data Set (MDS), a standardized assessment and care-screening tool), dated December 28, 2017 indicated Resident 47 had the ability to make self-understood and understood others. The resident required extensive to total assistance from staff with all his activities of daily living.

During record review on February 18, 2018 at 4:00 p.m., the POLST was missing the following:

1. POLST missing the date physician signed the form.

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c. A review of the clinical records indicated Resident 55 was re-admitted on December 15, 2017, with diagnoses that included heart failure (heart muscle is unable to pump enough blood through to meet the body's needs for blood and oxygen).

The Minimum Data Set (MDS), a standardized assessment and care-screening tool), dated January 10, 20178 indicated Resident 55 had the ability to make self-understood and understood others. The resident required limited to extensive assistance from staff with all his activities of daily living.

During record review on February 18, 2018 at 4:00 p.m. the POLST was missing the following:

1. POLST missing the date physician signed the form.

d. A reviewed of the admission records indicated Resident 59 was admitted to the facility on January 8, 2018 with diagnoses that included aphasia (loss of ability to understand or express speech, caused by brain damage).

A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated January 15, 2018 indicated Resident 59 rarely or never understood and rarely or never understood others. The resident required total assistance from staff with all her activities of daily

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F 578	Continued From page 6	F 578		

living.

During record review on February 18, 2018 at 4:00 p.m., no indication of Advance Directive found in Resident 59's clinical records.

e. A reviewed of the admission records indicated Resident 69 was admitted to the facility on January 15, 2018 with diagnoses that included dementia (loss of memory and other mental abilities severe enough to interfere with daily life).

A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated January 22, 2018 indicated Resident 69 usually had the ability to make self-understood and usually understood others. The resident required extensive to total assistance from staff with all her activities of daily living.

During record review on February 18, 2018 at 4:00 p.m., no indication of Advance Directive was found in Resident 69's clinical records.

f. A reviewed of the admission records indicated Resident 76 was re-admitted to the facility on October 28, 2017 with diagnoses that included chronic obstructive pulmonary disease (a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible).

A review of the Minimum Data Set (MDS), a

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standardized assessment and care-screening tool, dated January 22, 2018 indicated Resident 76 had the ability to understand and understood others. The resident required limited to total extensive assistance from staff with all his activities of daily living.

During record review on February 18, 2018 at 4:00 p.m., no indication of Advance Directive was found in Resident 76's clinical records.

g. A review of the clinical records indicated Resident 77 was re-admitted on January 12, 2018, with diagnoses that included dementia (loss of memory and other mental abilities severe enough to interfere with daily life).

The Minimum Data Set (MDS), a standardized assessment and care-screening tool), dated February 8, 2018 indicated Resident 77 usually had the ability to make self-understood and usually understood others. The resident required total assistance from staff with all her activities of daily living.

During record review on February 18, 2018 at 4:00 p.m. the POLST for Resident 77 was missing the following:

1. POLST missing the physician phone number and license number.

h. A review of the clinical records indicated Resident 78 was re-admitted on February 14,

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2018, with diagnoses that included end stage renal disease (kidneys no longer function well enough to meet the needs of daily life).

The Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated January 10, 2018 indicated Resident 78 usually had the ability to make self-understood and usually understood others. The resident required total assistance from staff with all her activities of daily living.

During record review on February 18, 2018 at 4:00 p.m. the POLST for Resident 78 was missing the following:

1. POLST missing the date physician sign the form.

i. A review of the clinical records indicated Resident 92 was re-admitted on January 30, 2018, with diagnoses that include heart failure (heart muscle is unable to pump enough blood through to meet the body's needs for blood and oxygen).

The Minimum Data Set (MDS), a standardized assessment and care-screening tool), dated January 10, 2018 indicated Resident 92 usually had the ability to make self-understood and usually understood others. The resident required extensive to total assistance from staff with all his activities of daily living.

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F 578	Continued From page 9 During record review on February 18, 2018 at 4:00 p.m. the POLST for Resident 92 was missing the following: 1. POLST missing the physician phone number, license number and date sign the form. During an interview with the Social Services on February 18, 2018 at 4:00 p.m., acknowledged no Advance Directives and missing information on the POLST. A review of the facility's policy and procedure with a revised date of February 2017 titled "Advance Healthcare Directive", indicate the following: To provide residents with the opportunity to make decisions regarding their healthcare and treatment options. At the time of admission, Admission staff or designee will inquire about the existence of an Advance Healthcare Directive. Upon admission, admission staff or designee will inform the resident of his/her right to execute an Advance Healthcare Directive.	F 578		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be	F 582		

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charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the

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facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure each Medicaid (is a jointly funded, Federal-State health insurance program for low-income and needy people) eligible resident was given Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Noncoverage ([ABN] a notice a provider gives before receiving services if, based on Medicare coverage rules, the provider has reason to believe Medicare will not pay for the services) in writing at the time of admission to the facility and when the resident became eligible for Medicaid for two of three randomly sampled residents (RSR 1 and RSR 2).

This deficient practice had the potential for the residents not knowing what services Medicaid program covered.

Findings:

A review of the facility's entrance conference worksheet indicated 18 residents were discharged from the facility from 10/24/2017 to 1/20/2018. Three randomly selected residents were sampled and two of 3 RSR residents were not given a generic note in writing.

a. A review of the Admission Records indicated RSR 1 was admitted to the facility on 11/20/2017 with diagnoses that included but was not limited to chronic obstructive pulmonary disease (lung disease).

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RSR 1's Beneficiary Protection Notification Review (BPNR) indicated Medicare part A skilled services episode dated 8/1/2017 and last covered days of part A services was dated 8/14/2018. The form indicated RSR 1 was discharged to the hospital. However, there was no documented evidence to show the beneficiary or the beneficiary's representative acknowledged a copy of the SNF ABN.

b. A review of the Admission Records indicated RSR 2 was admitted to the facility on 11/20/2017 with diagnoses that included but was not limited to cellulitis (bacterial skin infection) of the right lower limb (leg).

RSR 2's Beneficiary Protection Notification Review indicated Medicare Part A skilled services episode dated 11/20/2017 and last covered days of part A services was dated 11/21/2017. The form indicated RSR 2 was discharged to another SNF. However, there was no documented evidence to show the beneficiary or the beneficiary's representative acknowledged a copy of the SNF ABN.

On 2/18/18 at 12:30 p.m., during an interview with Social Services stated BPNR
was not given to the residents when discharged. The Social Services stated Medicaid eligible residents who were admitted and discharged from the facility were not given appropriate BPNR.

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F 584 SS=E	Continued From page 13 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584	F 584	

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to

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81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation and interviews, the facility failed to provide a homelike environment by lacking seasonal indication throughout the facility making it appear institutionalized and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior evidenced by chipped, peeling paint on doors, walls and baseboards.

According to the Resident Census and Condition of Resident indicated there were total 76 resident censuses with a licensed capacity of 88 beds.

This deficient practice had the potential to create a poor quality of life that may lead to depression due to its institutionalized appearance and unkempt living conditions.

Findings:

On February 16, 2018 at 5:30 p.m., during a general observation tour the facility appeared institutionalized, lacked seasonal indication, and it did not provide a clean, sanitary and orderly environment.

On February 18, 2018 at 10:00 a.m., during a tour of the facility with the Maintenance Supervisor (MS) the following was observed which was also confirmed by the MS:

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1. The following resident Rooms were observed with chipped, peeling paint on entry doors, bathroom doors, closet doors, baseboards along with stained privacy curtains in the resident Rooms: 12, 16, 17, 19 and 21.

2. The smoking and nonsmoking patio walls, ground, furniture were dusty and stained.

3. The resident's activity/dining room had broken blinds that appeared institutionalized.

During an interview with the Administrator on February 17, 2018 at 2:15 p.m., acknowledged the smoking and nonsmoking patio walls, ground, furniture which was dusty/stained furniture and activity room that had broken blinds.

During an interview with the Activity Director on February 17, 2018 at 2:15 p.m., acknowledged the smoking and nonsmoking patio walls, ground, furniture were dusty/stained furniture and activity room that had broken blinds.

A review of the facility's policy and procedure with a revised date of January 1, 2012 titled "Resident Rooms and Environment", indicated to provide residents with a safe, clean, comfortable and homelike environment. The facility provides residents with a safe clean comfortable and homelike environment. Facility staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents comfort, independence, and personal needs and preferences. To this ends, the facility

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encourages residents to use their personal belongings to the extent possible.

F 641 SS=D Accuracy of Assessments
CFR(s): 483.20(g)

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on interview and records review, the facility failed to ensure one of 18 sampled residents (Resident 53), assessment accurately reflected and triggered in the Minimum Data Set ([MDS] a standardized assessment and care screening tool) under the section K0300 for weight loss; nutritional approaches and proportion of total calories the resident received was trigger in section I (active diagnoses) of the MDS.

This deficient practice had the potential for residents not to receive necessary treatment and services.

Findings:

A review of Resident 53's Admission Records indicated the resident was readmitted to the facility on 11/9/2017 with diagnoses that included which were not limited to hepatic failure (liver not functioning properly) without coma.

A review of Resident 53's MDS assessment dated 12/20/2017 and 1/17/2018, indicated the resident usually made self-understood and

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understood others, had no impairment in cognitive skills, and required extensive assistance from staff with activities of daily living. The same comprehensive MDS dated 1/17/2018, section K0300 for weight loss, did not trigger for weight loss. The MDS k0300 was coded zero (0) which indicated the resident did not experienced any weight loss.

A review of the Initial Vital Sign Admission sheet dated 11/9/2017 indicated Resident 53 weighed 92 pounds (lbs).

A review of the Nutritional Assessment (NA) dated 11/9/17 indicated Resident 53 was on puree, low salt diet, honey thick liquid. The NA indicated ideal body weight (IBW) of 120-101 (73%).

A review of Resident 53's weight log indicated the weights as followed:
11/1/2017 wt. 115 lb;
12/1/2017 wt. 88 lbs;
1/8/2018 wt. 93 lbs,
1/15/2018 wt. 96 lbs,
1/22/2018 wt. 98 lbs,
1/29/2018 wt. 98 lbs,
1/8/2018 wt. 93 lb,
1/15/2018 wt. 96 lbs,
1/22/2018 wt. 98 lbs,
1/29/2018 wt. 98 lbs,
2/5/2018 wt. 98 lbs,
2/12/2018 wt. 97 lbs

A review of the Quarterly Nutritional Assessment

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dated 12/12/2017 indicated Resident 53 had significant weight loss of 29 pounds. According to NA dated 2/1/2018 revealed the resident weighted at 98, lbs. The total weight loss for three months was equal to (=) 115-98 = 17/98X100 = 17.3% significant weight loss.

A review of the laboratory results for Resident 53 dated 1/12/2018 indicated pre albumin was 18 at a range 17 to 34 and albumen was 3.5 at a range of 3.5 to 5.7, Hemoglobin 11.7 (11.2 to 15.7) and Hematocrit 36.8 (34.1 to 44.9).

On 2/17/18 at 6:29 p.m., during an interview the MDS coordinator stated she failed to review Resident 53's clinical records for a" look back in one month and 6 months" during the quarterly and annual assessment periods.

According to the facility's policy and procedures titled "Resident Assessment Process" dated 10/4/2016 indicated that MDS coordinator review all resident's clinical records to provide resident assessments that accurately depict and identify resident specific issues and objectives as required, while meeting state and Federal guidelines and data submission requirements.

F 658 SS=E — Services Provided Meet Professional Standards — F 658
CFR(s): 483.21(b)(3)(i)

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to follow professional standards of practice for one of 18 sampled residents (Resident 55) during medication administration.

1. A licensed vocational nurse (LVN 6) checked Resident 55's blood sugar at 9 a.m., without a physician's order.

2. LVN 6 failed to identify the resident prior to administering insulin.

3. LVN 6 failed to document the blood sugar readings after checking Resident 55's blood sugar.

4. LVN 6 failed to cross check insulin order on the medication administration record (MAR) prior to administering.

5. LVN 6 failed to pull back insulin syringe to ensure the needle was not in a blood vessel.

6. LVN 6 failed to administer insulin subcutaneously ([SQ] under the skin), as ordered.

7. LVN 6 administered medications to Resident 55 but failed to document in the MAR and was observed walking into another resident's room.

These deficient practices placed Resident 55 at risk for pain, discomfort and had the potential to result in residents receiving wrong medications.

Findings:

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A review of Resident 55's Admission Face Sheet indicated the resident was admitted to the facility on 2/15/12 with a recent admission on 12/15/17. Resident 55 had diagnoses including diabetes ([DM] abnormal blood sugar), muscle weakness and hypertension (high blood pressure).

A review of Resident 55's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 9/28/17 indicated Resident 55 was able to understand and be understood by others. According to the MDS, Resident 55 depended on one staff's assistance moving from one place to another, dressing, toilet use and personal hygiene. The resident used a walker or wheelchair to ease movement. Resident 55's MDS also indicated the resident had DM and was on insulin injections (medication for DM).

A review of Resident 55's physician orders dated 12/15/17, indicated the resident was to receive 64 units of NPH 70/30 (a type of insulin) subcutaneously (under the skin) at 9 a.m., and 25 units at bed time, every day. The physician also ordered indicated Resident 55 had to have blood sugar checks done.

A review of Resident 55's history and physical (H/P) dated 1/1/18, indicated the resident had the capacity to understand and make decisions.

A review of Resident 55's "Insulin and Glucose

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Administration Record" dated 2/1-18/2018, indicated the residents blood sugar was supposed to be checked at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9 p.m., every day.

A review of Resident 55's care plan dated 12/15/17 indicated the resident had a potential for injury due to low blood sugar. The care plan identified Resident 55 at risk for injury, due to neuropathy (decrease sensation in the hands and feet). The interventions indicated the resident's skin would be monitored for redness, skin breakdown and decreased circulation. It also indicated that the staff would administer Resident 55's medications as ordered by the physician.

On 2/17/18, at 9 a.m., during an observation, LVN 6 performed accu check (blood sugar check) on Resident 55 after the resident had eaten breakfast and without a physician's order. LVN 6 failed to document the results of the blood sugar. LVN 6 administer 64 units of NPH insulin to the resident, but failed to do the following: identify the resident, pull the syringe back to ensure it was not in a blood vessel, failed to use the SQ technique in administering the insulin, and failed to document medications administered on Resident 55's MAR. LVN 6 was then observed walking into another resident's room.

On 2/17/18 at 10:15 a.m., during a concurrent observation, interview and record review, LVN 6 was documenting medications administered to Resident 55, at the nurses' station. LVN 6 stated she forgot to document on time. According to the LVN, she should have documented all

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medications administered before leaving Resident 55's room. LVN 6 also stated before giving insulin, she usually checked residents' blood sugar even if previously checked. The LVN 6 added because Resident 55 was fat, it was okay to administer the insulin through the intramuscular ([IM] into the muscle) and not the SQ route as ordered by the physician.

02/17/18 02:46 p.m., during a concurrent interview and record review, LVN 6 stated she did not document the 9 a.m., blood sugar levels because there was no space in the MAR for it to be documented. LVN 6 added she would endorse the blood sugar results to the next shift. According to LVN 6, she should have documented the results somewhere. LVN 6 stated blood sugar check was like vital signs and if requested by a resident or family the nurse did not require a physician's orders. According to LVN 6, Resident 55 did not have any symptoms of low or high blood sugar and added that she always checked the resident's blood sugar at 9 a.m., prior to administering insulin. The LVN stated she should have pulled skin prior to administering insulin, should have applied pressure to site post insulin administration but she did not. According to LVN 6, she was nervous and forgot to properly identify the resident, failed to verify MAR prior to administering the insulin dose and stated she would do better next time.

On 02/18/18 at 12:02 p.m., during a concurrent interview and record review, LVN 6 stated she did not check Resident 55's blood sugar but administered 64 units of NPH 70/30 insulin. A

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review of the resident's MAR indicated at 6:30 a.m., Resident 55's blood sugar was 69 mg/dl. LVN 6 stated the resident refused to have his blood sugar checked at 9 a.m.

On 02/18/18 at 12:18 p.m., during an interview and in the presence of LVN 6, Resident 55 stated he never refused accu check at 9 a.m. According to LVN 6, the resident was forgetful.

On 2/18/18 at 3:06 p.m., during a concurrent interview and record review a registered nurse (RN 2) stated accu checks were done per physician's orders and in case of an emergency. RN 2 also stated if a resident requested additional accu check to be done, the physician still had to give orders.

A review of the facility's policy and procedures titled "Physician Orders," dated 1/1/12, indicated the licensed nurse would document and implement the physician's orders. The policy also indicated documentation on physician orders would be maintained in the resident's medical record.

A review of another facility's policy and procedures titled "Specific Medication Administration Procedures" indicated insulin was to be administered correctly to control blood sugar levels in residents with DM. According to the policy, the licensed staff would prepare the injection as follows: check medication on the label with the MAR three times, withdraw the right amount of medication ordered, and expel air from

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F 658	Continued From page 24 the syringe, after inserting the needle into the resident, the staff would pull the plunger back to ensure the needle was not in the blood vessel. It also indicated after administering insulin to a resident, the nurse would remove the needle and apply firm pressure over the site to prevent seepage of insulin. According to the policy, the nurse had to document the administration of the injection on the MAR.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676		

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§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and records review, the facility failed to provide the necessary level of assistance that meets the resident's current needs by not off loading heels with pillows as ordered and to turn and reposition every two hours as indicated in plan of care for one of 18 sampled residents (Resident 48).

This deficient practice had the potential to have caused a facility-acquired sacral pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) Stage 2 and bilateral heel pressure ulcer for Resident 48.

Findings:

On 2/16/2018 at 8 a.m. to 2 p.m., Resident 48 was observed lying in a supine (back) position. On 2/17/2018 at 7:30 to 4:45 observed the resident lying on her back. On 2/18/2018 at 9 a.m., after the bed bath, the resident was observation turned to the right side until 2:30 p.m., when certified nursing assistant CNA 1 provided bowel incontinent care.

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A review of Resident 48's admission records indicated she was readmitted to the facility on 7/172017 with diagnoses that included Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and dysphagia (inability to swallow and liquid or food)

A review of the Resident 48's History and Physical Examination form dated 7/22/2017 indicated the resident did not have the capacity to understand and make decisions.

A review of Resident 48's Minimum Data Set (MDS), standardized assessment and care screening tool, dated 1/16/2018 indicated the resident was severely impaired with daily decision making skills and required total dependence on full staff performance assistance with bed eating, mobility, transfers, toileting, hygiene and bathing.

A review of the Resident 48's care plan for "skin-short term non- pressure ulcer" dated 10/5/2017, indicated sacral wound and bilateral heels wounds. The goals included skin condition will heal within thirty days and the resident will be free from further skin breakdown. The interventions indicated turning and repositioning as scheduled. Bilateral heels float off load with pillows at all times.

Another care plan for Resident 48 indicated "alteration in skin" due to acquired pressure sore on the right heels and on 2/6/2018 indicated

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sacral pressure ulcer Stage 2. The goals were the resident will have no further skin breakdown and intervention was turning and reposition every two hours.

A review of the weekly pressure injury progress reports for Resident 48 dated 1/23/2018 indicated right heel deep tissue injury measured length (L) 3.4 centimeter (cc), width (W) 3.6; 1/30/2018 L = 3.9cc, W = 3.4 cc; 2/6/2018 right heel 1 = 3.6 cc, W = 3.2 cc and sacral pressure ulcer stage 2 L = 3.9 cc and W = 2.6 cc.

On 2/18/2018 at 2:45 p.m., during an interview with certified nurse assistant (CNA) 1 stated Resident 48 required assistance with turning and repositioning every 2 hours because of the Stage 2 pressure ulcer on her coccyx area. When asked if the facility's turning and reposition every two hours scheduled was hung over head of the bed for each resident, including Resident 48, CNA 1 had no comment.

On 2/18/2018 at 3:10 p.m., during an interview with Resident 48's family member (FM) stated she did not see any staff come into the room to turn the resident. FM 48 stated the resident smelled of urine at the time.

According to the facility's policy and procedures titled "Positioning and Body Alignment" dated 1/1/2012, indicated each resident who is partially or totally dependent will be turned and positioned every two hours to maintain range of motion of the joints, to prevent deformity and decrease

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F 676	Continued From page 28 contractures and to increase the functional use of the extremity.	F 676		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide ongoing activities to meet the interests and psychosocial well-being of each resident for eight of 8 alert and oriented residents during group meeting. The residents during group meeting expressed the lack of community outings (occurs outside facility). Failure to provide activities to meet the residents' needs created feelings of boredom, disappointment and dissatisfaction. According to the Resident Census and Condition of Residents indicated there were total 76 resident censuses with a licensed capacity of 88 beds.	F 679		

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F 679	Continued From page 29 Findings:	F 679		

On February 18, 2018 at 3:29 p.m., during the group meeting eight of 8 alert and oriented residents stated they have not gone out on an outing since September 2017.

During an interview the on February 18, 2018 at 4:34 p.m., with Social Services stated she was the activity director in September 2017. The Social Services acknowledged the residents had no outings and was unable to provide a log for outings.

During an interview with the Administrator on February 18, 2018 at 4:34 p.m., acknowledged the residents had no outings and was unable to provide a log for outings.

During an interview with the current Activity Director on February 18, 2018 at 4:34 p.m., acknowledged the residents had no outings and was unable to provide a log for outing.

A review of the facility's policy and procedure titled "Community Outings" revised date of November 1, 2013, indicate the following: to promote the psychosocial development of residents through community based activities. All community outings are planned by Director of Activities allow residents continued participation in the community and programs off-site as necessary and appropriate. The Director of Activities may document the details of the outing

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activity plan using CT-06-Form A- Outing Report.

F 684 Quality of Care F 684
SS=E CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to properly demonstrate how to check apical pulse (AP, heart beat that could be heard with a stethoscope [medical device] over the fifth intercostal space, between the ribs) as ordered by the physician for one out of 18 sampled residents (Resident 48). This deficient practice placed Resident 48 at risk for unrecognized pacemaker (a medical device that uses electrical impulses to contract the heart to regulate the beating of the heart) malfunction and subsequently death.

Findings:

A review of Resident 48's admission records indicated she was readmitted to the facility on 7/17/2017, with diagnoses that included muscles weakness, upper and lower extremities contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints).

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A review of the Resident 48's record titled, "History and Physical Examination," dated 7/22/2017, indicated the resident did not have the capacity to understand and make decisions.

A review of Resident 48's record titled, "Minimum Data Set (MDS, standardized primary screening and assessment tool of health status)," dated 1/16/2018, indicated the resident was severely impaired with cognitive skills (set of mental abilities or processes) for daily decision making skills and was totally dependent on the staff with eating, bed mobility, transfers, toileting, hygiene and bathing. The MDS indicated that Resident 48 had functional limitation on both upper and lower extremities.

A review of Resident 48's recapitulated physician's orders, dated 2/2018, indicated to monitor for apical pulse (AP) every shift on 7 a.m., to 3 p.m., shift daily, record in the resident's clinical records and call the physician if AP < (less than) 60.

A review of Resident 48's clinical records indicated that a pacemaker was implanted on 4/5/2007.

A review of Resident 48's care plan for risk of pacemaker malfunction related to diagnosis of heart failure. The nursing interventions indicated for the staff to check apical pulse every shift, perform pacemaker check-up schedule and notify medical doctor of any abnormality seen/ observed or reported by resident.

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On 2/17/2018, at 8: 50 a.m., Licensed Vocational Nurse 2 (LVN 2) was observed assessing Resident 48's apical pulse on the inside of the elbow (brachial pulse). During an interview with LVN 1, she was unable to locate the anatomic landmarks for the apical pulse. When asked if LVN 2 knows the anatomic landmarks, LVN 2 held her radial artery (located on the wrist), later on, she pointed to her carotid artery (located on the neck).

On 2/19/18, at 1:09 p.m., during an interview with LVN 7, who administered medication to Resident 48, LVN 7 was not aware that Resident 48 had a pacemaker. When LVN 7 was asked to demonstrate how to monitor AP, she was not able to properly demonstrate how to check AP for resident with pacemaker. LVN 7 stated to put the stethoscope in the resident's left upper chest. LVN 7 was unable to state where the stethoscope was to be placed specifically.

On 2/19/2018, at 4:15 p.m., during an interview, LVN 3 stated the ball of the stethoscope (a device that amplifies sounds) has to be placed on the left chest above the nipple or on the "first intercostal space."

F 688 SS=D — Increase/Prevent Decrease in ROM/Mobility
CFR(s): 483.25(c)(1)-(3)

§483.25(c) Mobility.
§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

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§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure range of motion (ROM) exercises was provided completely and to apply elbow splint (a device used for support or immobilization of a limb or the spine) as ordered by the physician for one out of 18 sampled residents (Resident 48). This deficient practice had the potential to cause further decline to Resident 48's extremities, discomfort, and increase joint deformity.

Findings:

On 2/17/2018 at 9:24 a.m., Resident 48 was observed in her room lying in bed. Restorative Nursing Assistant (RNA I) was performing passive ROM exercises (therapist moves the resident's joints through the range of motion with no effort from the resident) to the resident's upper and lower extremities. Upon completion of the exercises, RNA 1 did not perform abduction (moving a limb away from the midline of the body), adduction (a movement which brings a limb closer to the body) and extension (straightening movement that increases the angle between the bones at the joint) to Resident 48's legs. RNA I did not apply Resident 48's elbow

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splints after the ROM exercises.

A review of Resident 48's admission records indicated she was readmitted to the facility on 7/17/2017, with diagnoses that included muscles weakness, upper and lower extremities contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints).

A review of the Resident 48's record titled, "History and Physical Examination," dated 7/22/2017, indicated the resident did not have the capacity to understand and make decisions.

A review of Resident 48's record titled, "Minimum Data Set (MDS, standardized primary screening and assessment tool of health status)," dated 1/16/2018, indicated the resident was severely impaired with cognitive skills (set of mental abilities or processes) for daily decision making and was totally dependent on the staff with eating, bed mobility, transfers, toileting, hygiene and bathing. The MDS indicated that Resident 48 had functional limitation on both upper and lower extremities.

A review of Resident 48's physician's order summary, dated 2/2018, indicated RNA program (provide specific treatments to residents so to restore and maintain the strength, coordination and skills to ambulate and perform functional activities of daily living) for passive range of motion (PROM) of the right and left lower extremities every day, five times a week or as tolerated. RNA program for PROM to the right and left upper extremities every day, five times a week or as tolerated. RNA program to apply right and left elbow splints every day, seven days a

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week for four (4) to six (6) hours or as tolerated. Skin check after each use.

A review of Resident 48's care plan for "restorative nursing treatment," dated 7/18/2017, indicated the resident had limitations on the joints. The goal included for Resident 48 would not develop complications related to contractures. The interventions included for the staff to perform PROM two times a day, five times a week, and to apply elbow splints to both arms as ordered.

On 2/18/2018, at 3:10 p.m., during an interview, RNA 1 stated he forgot to complete the exercises with Resident 48 and forgot to apply the splints.

F 689 SS=E Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) F 689

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility's nursing staff failed to ensure the safety of one of 18 sampled residents (Resident 76) and seven non sampled residents indicated on the facility list of smoking residents. These deficient practices placed residents at risk of burn injury. At the time of the observation, according to the Resident Census and Condition of Resident indicated the census was 76 with a licensed capacity of 88 beds.

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Findings:

a. A review of the admission records indicated Resident 76 was re-admitted to the facility on October 28, 2017, with diagnoses that included chronic obstructive pulmonary disease (COPD is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible).

A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated January 22, 2018, indicated Resident 76 had the ability to understand and understood others. The resident required limited to extensive assistance from staff with all his activities of daily living.

During an interview on February 17, 2018, at 2:00 p.m., Resident 76 was asked about having his cigarette lighters and cigars at bedside. Resident 76 stated he kept his cigarette lighters and cigarettes at the bedside.

A review of Resident 76's plan of care, dated November 17, 2017, indicated to store smoking and incendiary related material (that could cause fire) per facility policy. Assist resident to and from designated smoking area, as required.

b. During a general observation of the smoking patio on February 19, 2018, seven residents were observed smoking without being supervised by staff, having in their possession cigarettes, lighters, and smoking without aprons during the following times:

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1. 8:40 a.m. - 9:15 a.m.
2. 11:00 p.m. - 11:15 p.m.
3. 1:00 p.m. - 1:15 p.m.
4. 3:00 p.m. - 3:15 p.m.

During an interview on February 19, 2018, at 5:00 p.m., with Central Supply 21, he stated if a resident is alert and does not see anybody out there, he does not go out.

During an interview on February 19, 2018, at 5:00 p.m., with Restorative Nursing Assistant (RNA 20) he stated he was out there.

During an interview on February 19, 2018, at 5:00 p.m., with Activity Director, he stated he was not out there.

During an interview on February 19, 2018, at 5:00 p.m., with Registered Nursing 2 (RN 2), he stated resident should not have cigarette lighters or cigars at bedside, staff was schedule to supervise and he(RN 2) made rounds to see if residents were being supervised.

A review of facility's "Smoking Schedule" indicate the follow:

1. Residents who do not require supervision while smoking may smoke at all hours.
2. Residents who do require supervision while smoking will follow schedule

8:40 a.m. - 9:15 a.m. (Central Supply 21)

11:00 p.m. - 11:15 p.m. (Central Supply 21)

1:00 p.m. - 1:15 p.m. (Activity

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Assistant)
3:00 p.m. - 3:15 p.m. (RNA 20)
6:00 p.m. - 6:15 p.m. (CNA)

A review of facility's policy and procedures title, "Smoking by Residents", revised date of January 2017 indicated the following:

1. To provide a safe environment for residents, staff and visitors.

2. It is the policy of this facility to accommodate residents who desire to smoke by taking reasonable precautions providing a safe environment for them, and protecting the non-smoking residents. Smoking whether it is traditional tobacco or herbs (does not include marijuana or its derivatives smoked in cigarette, pipes, cigars or electronic cigarettes) are governed by this policy.

3. The facility may develop a smoking schedule to ensure a safe environment.

F 690 SS=D Bowel/Bladder Incontinence, Catheter, UTI
CFR(s): 483.25(e)(1)-(3) — F 690

§483.25(e) Incontinence.
§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must

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ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility's staff failed to ensure that residents with an indwelling urinary catheter ([f/c] a flexible tube passed into the bladder to allow urine to drain) received the necessary care and treatment to prevent infection for one of three sampled residents (Resident 12). Resident 12, who had a history of urinary tract infections ([UTI] an infection in any part of the urinary system-kidneys, ureters, bladder and urethra), was observed with sediments (cream colored particles) in his f/c from 2/16-18/2018. The f/c was also observed lying on the floor for 15 minutes. These deficient practices had the

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potential for bacteria to enter the tubing as well as resulting in a UTI for Resident 12 and the other residents with urinary catheters.

Findings:

On 2/16/18 at 6 p.m., Resident 12 was observed lying in bed. Resident 12 was observed with 100 cubic centimeters (cc) of cloudy urine with cream-colored sediments.

A review of Resident 12's Admission Face Sheet indicated the resident was admitted to the facility on 10/24/17 with a recent admission on 1/5/18. Resident 12 had diagnoses including muscle weakness, benign prostatic hyperplasia ([BPH] enlarged prostate) and a urinary device (f/c).

A review of Resident 12's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 11/11/17, indicated the resident was able to understand and be understood by others. According to the MDS, Resident 12 depended on two or more staff's assistance for activities of daily living (ADL). The resident had an indwelling catheter (f/c). The MDS also indicated Resident 12 had a diagnosis of BPH and was on diuretics (water pill).

A review of Resident 12's history and physical (H/P), dated 1/7/18 indicated the resident did not have the capacity to understand and make decisions.

A review of Resident 12's physician's orders, dated 1/5-31/18, indicated Resident 12 was to have a f/c care daily and as needed. Resident 12's f/c was to be cleaned using water and soap. The resident's f/c was also to be changed if

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leaking or pulled out.

A review of Resident 12's care plan, dated 1/6/18, indicated the resident had an indwelling urinary catheter due to urinary retention, BPH, history of UTI and with nephrostomy (an artificial opening between the kidney and skin used to redirect urine from the upper part of the urinary system). The intervention for this care plan indicated the facility's staff would monitor Resident 12 for signs and symptoms (s/s) of UTI, skin breakdown, intake and output (I/O). The staff was to provide catheter care per physician's order and ensure that the urine collector bag was below the bladder. A review of Resident 12's care plan, dated 1/8/18, indicated Resident 12 was at risk for incontinence due to BPH and that the resident had a history of UTI. The intervention for this care plan indicated the treatment nurse would provide catheter care to the resident using soap and water.

A review of another care plan, dated 1/6/18, indicated Resident 12 had a potential for bladder distention, UTI and discomfort. According to the interventions for this care plan, the staff had to encourage the resident to drink fluids every shift and monitor for s/s of UTI. The care plan interventions indicated staff had to promptly notify the physician of any change in condition.

A review of Resident 12's Certified Nursing Assistant (CNA) communication note, dated 2/12/18, indicated 600cc of urine was emptied from the f/c. This note failed to indicate the presence of sediments in the f/c. A review of Resident 12's "Intake and Output Record" dated 2/4/18, indicated the urine output for the entire day totaled 1,348 cc.

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A review of Resident 12's nurses' notes from 2/9-17/2018 failed to indicate the resident's urine was cloudy and had sediments in his f/c.

On 2/17/18, at 7:41 a.m., during a concurrent observation and interview, the resident's f/c was observed to have cream colored, mucus -looking sediments and light brown marks on the outer portion of the tubing. Resident 12 stated that he had the f/c for three months due to kidney stones. The resident stated that he was treated for UTI 2 months ago.

On 02/17/18, at 1:40 p.m., during a concurrent observation and interview, Resident 12's f/c was observed with a scant amount of cloudy output and brown substances outside the tubing. A licensed vocational nurse (LVN 1) stated the treatment nurse was responsible for providing catheter care to all the residents with f/c. LVN 1 stated that she would offer more fluids to Resident 12 to flush the resident's bladder so that the output could be clear.

On 02/18/18 07:04 a.m., during a concurrent observation, interview and record review, Resident 12's f/c was observed with 150 cubic centimeters (cc) of cloudy urine containing cream colored sediments. LVN 5 stated Resident 12's f/c contained sediments and that she failed to assess the resident's f/c, on 2/17/18. LVN 5 stated that Resident 12's certified nursing assistant (CNA 4) did not tell her the resident's urine output had sediments.

On 2/18/18, at 07:20 a.m., during an interview, LVN 5 stated that she did not receive endorsement from LVN 1 regarding the

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sediments on Resident 12's f/c. According to LVN 5, the staff was supposed to endorse care at the start and end of shifts with emphasis on important issues like change of condition (COC). According to LVN 5, the presence of sediments in Resident 12's f/c would be communicated to the resident's physician promptly.

On 2/18/18, at 7:40 a.m., during a telephone interview, CNA 4 stated that Resident 12's urine output was cloudy and that CNAs were supposed to notify charge nurses (CN) and recorded in a communication book any changes in residents' condition. CNA 4 stated that she failed to notify the CN. According to CNA 4, she did not endorse Resident 12's care to the incoming staff. CNA 4 added that she did not receive endorsement from the outgoing staff either. According to CNA 4 before clocking out from work, she was supposed to endorse residents care to the incoming nurse but she did not.

On 2/18/18, at 2:26 p.m., during an observation, Resident 12's f/c bag was observed lying on the floor for 15 minutes. The urine output in the tubing contained visible cream-colored sediments.

On 2/18/18, at 2:30 p.m., during a concurrent observation and interview, LVN 7 stated that Resident 12's f/c bag was on the floor and that it was not supposed to be on the floor. LVN 7 added that she would fix it. LVN 7 was observed walking away from Resident 12's room. LVN 7 was observed at the hallway in front of Resident 12's room, charting on a medication administration record (MAR). LVN 7 proceeded to clean a BP cuff that was on top of her cart.

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On 2/18/18, 2:37 p.m., during a concurrent observation and interview, a water pitcher was observed on Resident 12's bedside table. Resident 12 stated that the staff did not offer him fluids often.

On 2/18/18, at 2:38 p.m., during an observation and interview, LVN 7 returned to Resident 12's room and stated that the resident's f/c should not be on the floor. According to LVN 7, the bag fell because it was filled with urine. Resident 12's f/c contained 1000cc of urine that was cloudy and had cream-colored sediments. LVN 7 stated that she took care of the resident on 2/17/18 but did not notice sediments in his urine output. According to LVN 7, she should have notified Resident 12's physician about the presence of sediments in his f/c for prompt treatment.

On 2/18/18, at 3:10 p.m., during a concurrent observation and interview, a registered nurse (RN 1) stated Resident 12's urine had sediments, probably because the resident was not drinking enough fluids. RN 1 added that she would provide fluids to the resident and flush the resident's catheter, to get rid of the sediments.

A review of the facility's policy with a revision date of 1/1/12, titled, "24 Hour Communication," indicated the facility would utilize a 24-hour report system to communicate changes in condition, other important aspects of residents' care and census information. According to this policy, the licensed nurse that identified a change in the resident's condition would enter the condition on the log and discuss changes at the transition of each shift. The CNAs and licensed nurses were supposed to communicate any important aspects of residents care.

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A review of another policy titled, "Change of Condition Notification," with a revision date of 4/1/15, indicated the purpose of the policy was to ensure residents, family and physicians were to be informed of changes in resident's condition in a timely manner. According to this policy, whoever noticed the COC was to report to a licensed nurse. The nurse had to observe and assess the resident, document any COC and then notify the resident's physician.

F 725 SS=E Sufficient Nursing Staff
CFR(s): 483.35(a)(1)(2) — F 725

§483.35(a) Sufficient Staff.
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under

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paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure call lights were answered in a timely manner for three of eighteen sampled residents (Resident 10, 53 and 47), and three of four out of seven randomly selected residents (RSR 5, 19, 84, and 45). These deficient practices resulted in residents' needs not met timely and had a potential to result in falls and skin injuries.

Findings:

A review of the facility's Resident's Council Meeting minutes, from December 2017 to February 2018 indicated the residents who attended the council meetings complained about call lights not being answered in a timely manner.

On 02/18/18, at 03:29 p.m., during the group meeting, five of the eight alert residents who attended the group meeting stated that call lights during the night shift were not answered in a timely manner. According to these residents, charge nurses were usually the ones who responded to call lights and not the CNAs.

1. A review of RSR 45's Admission Face Sheet indicated the resident was admitted to the facility on 5/12/17, with the most recent readmission on 5/12/17. RSR 45's diagnoses included osteomyelitis (bone infection), diabetes (high blood sugar) and hypertension ([htn] high blood pressure).

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A review of RSR 45's history and physical report (H/P), dated 4/3/17, indicated the resident had the capacity to understand and make decisions.

A review of RSR 45's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 12/22/17, indicated the resident was able to understand and be understood by others. According to the MDS, RSR 45 depended on a facility's staff for activities of daily living (ADL).

On 2/19/18, at 2 p.m., during an interview, RSR 45 stated that the facility's staff did not respond to call lights in a timely manner. According to RSR 45, it sometimes took over 30 minutes for call lights to be answered and he added that he wondered what the residents who were unable to make needs known had to go through.

2. A review of RSR 5's Admission Face Sheet indicated the resident was admitted to the facility on 10/16/17, with diagnoses including cerebral infarct (stroke) and difficulty walking.

A review of RSR 5's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 1/22/18, indicated the resident was able to understand and be understood by others. According to the MDS, RSR 5 depended on two or more staff's assistance for activities of daily living (ADL).

On 2/19/18, at 2:12 p.m., during an interview RSR 5 stated that during the night shift, the CNAs rarely answered call lights and whenever they did, it took as long as 45 minutes sometimes. According to the resident, he could be calling for an emergency and the staff need to answer call lights as soon as they can. According to RSR 5,

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the CNAs had been caught sleeping downstairs in the break room instead of attending to residents' needs.

3. A review of Resident 47's Admission Face Sheet indicated the resident was admitted to the facility on 3/29/12 with the most recent admission on 1/16/18. Resident 47's diagnoses included complete paraplegia (weakness of the lower part of the body) and high blood sugar.

A review of Resident 47's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 1/22/18, indicated the resident was able to understand and be understood by others. According to the MDS, Resident 47 depended on two or more staff's assistance for activities of daily living (ADL).

On 2/19/18, at 2:22 p.m., during an interview, Resident 47 stated during the evening shift, call lights were hardly answered by the nurses. Resident 47 stated the charge nurses would answer call lights after a long time because the CNAs were busy sleeping.

4. A review of RSR 84's Admission Face Sheet indicated the resident was admitted to the facility on 1/19/18 with diagnoses including muscle weakness and difficulty walking.

A review of RSR 84's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 1/26/18, indicated the resident was cognitively impaired and was not able to understand and be understood by others. According to the MDS, RSR 84 depended on two or more staff's assistance for activities of daily living (ADL). The resident used a walker or

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wheelchair to ease movement.

A review of RSR 84's care plan, dated 1/20/18, indicated the resident required assistance with bed mobility, walking, dressing, toilet use and personal hygiene. The intervention of this care plan indicated the staff would provide assistance with ADLs as needed, turn and reposition the resident as needed.

On 2/19/18, at 5:34 a.m., RSR 84's room had a strong urine odor. RSR 84's sheets and gown were visibly wet with urine.

5. A review of Resident 53's Admission Face Sheet indicated the resident was admitted to the facility on 6/16/16 with a most recent admission on 11/9/17. The resident had diagnoses including muscle weakness and difficulty walking.

A review of Resident 53's H/P dated 11/13/17, indicated the resident did not have the capacity to understand and make decisions.

A review of Resident 53's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 1/6/18, indicated the resident was cognitively impaired and was not able to understand and be understood by others. According to the MDS, Resident 53 depended on two or more staff's assistance for activities of daily living (ADL). The resident used a walker to ease movement.

A review of Resident 53's care plan dated 11/19/17, indicated the resident required assistance with bed mobility, walking, dressing, toilet use and personal hygiene. The intervention of this care plan indicated the staff would provide

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assistance with ADLs as needed, turn and reposition the resident as needed.

On 2/19/18, at 5:34 a.m., Residents 53's room had a strong urine odor.

6. A review of Resident 10's Admission Face Sheet indicated the resident was admitted to the facility on 6/15/13, with a most recent admission on 2/8/17. Resident 10 had diagnoses including right sided hemiplegia (weakness on the right side of the body) and right hand, elbow and wrist contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints).

A review of Resident 10's undated H/P indicated the resident had the capacity to understand and make decisions.

A review of Resident 10's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 1/26/18, indicated the resident was able to understand and be understood by others. According to the MDS, Resident 10 depended on two or more staff's assistance for activities of daily living (ADL). The resident used a wheelchair to ease movement.

A review of Resident 10's care plan, dated 2/8/17, indicated the resident required assistance with bed mobility, walking, dressing, toilet use and personal hygiene. The intervention of this care plan indicated the staff would turn and reposition the resident as needed.

On 2/19/18, at 5:05a.m, during an observation, a licensed vocational nurse (LVN 1) was standing two doors from Room 11 passing medications.

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The call light indicator was visibly activated, but LVN 1 failed to answer.

On 02/19/18, at 05:20 a.m., during an observation, the call light in Room 11 was ringing and CNA 2 was observed walking by the room without answering the call light.

On 02/19/18, at 05:21 a.m., during an observation, CNA 1 was observed walking by Room 11 while the call light was on and she did not answer.

On 02/19/18, at 05:30 a.m., during a concurrent observation and interview, a licensed vocational nurse (LVN 1) stated CNAs were responsible for call lights and that the CNA for Room 11 usually left work at 5 a.m. LVN 1 also stated that CNA 3 had already left and that before leaving home, CNA 3 stated that all her residents were taken cared of. The call light in Room 11 rang for 32 minutes. According to LVN 1, CNA 2 barely went to answer the call light in Room 11. LVN 1 stated that she could not answer call lights because she was busy passing medications.

On 02/19/18, at 05:33 a.m., during an interview, CNA 1 stated call lights were the CNAs responsibility and that charge nurses (CN) had to answer call lights when the CNAS were busy. According to CNA 1, she did not see the call lights in Room 11.

On 2/19/18, at 5:34 a.m., Resident 10's room had a strong urine odor.

On 02/19/18, at 05:36 a.m., during an interview, CNA 2 stated that everyone was responsible for call lights. According to CNA 2, she saw the call

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lights but thought CNA 3 answered the lights because when the light went off, CNA 3 was observed in front of the room. CNA 2 stated she should have answered the call light. CNA 2 stated neglect is a form of abuse like not answering call lights or leaving the resident wet.

On 2/19/18, at 7:35 a.m., during a concurrent interview and record review with the facility's administrator (ADM) and director of nursing (DON), they both stated that they were not aware CNA 3 left work before 7 a.m. A review of CNA 3's "Time Detail from December to February, indicated CNA 3 clocked in to work at 12 a.m., and clocked out around 5:30 a.m., on most days. This record indicated on 2/19/18, CNA 3 clocked out from work at 4:57 a.m.

On 02/19/18, at 08:47 a.m., during an interview, the facility's director of staff development (DSD) stated that CNA 3 was hired for the 11-7p.m. shift and that she made special arrangements with CNA 3 to leave work at 5 a.m., because she had to go to her second job. According to DSD, she asked CNA 3 to always notify her charge nurse before leaving the facility so that her assignment could be reassigned to the other CNAs. The DSD stated that the ADM and DON were not aware CNA 3 would leave work early, whenever she worked. The DSD stated that night shift CNAs each had 12 or 18 resident depending on the census. The DSD added that CNA 3 either came to work at 12, 12:30a.m, because she came from another job.

On 2/19/18, at 8:58 a.m., during a telephone interview, CNA 3 stated that before leaving the facility at 5 a.m., she notified LVN 1 so that her assignment could be re-distributed to the other

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CNAs. According to CNA 3, she was authorized by the Director of Staff Development (DSD) to leave early every day because she had to go to her other job. CNA 3 stated that she did not abandon the residents and that it was LVN 1's responsibility to reassign her residents.

7. A review of RSR 19's Admission Face Sheet indicated the resident was admitted to the facility on 2/16/18 with diagnoses including end stage renal disease ([ESRD] kidney disease) and diabetes.

A review of RSR 19's care plan, dated 2/17/18, indicated the resident required assistance with bed mobility, walking, dressing, transfer, toilet use and personal hygiene. The intervention of this care plan indicated the staff would provide assistance with ADLs, turn, and reposition the resident as needed.

On 02/19/18, at 05:15 a.m., during an observation, RSR 19's call light was on but was not ringing at the Nurse's Station.

On 02/19/18, at 05:25 a.m., RSR 19 was observed yelling "senorita" (miss in Spanish), and a certified nursing assistant (CNA 1) was observed walking by the room without responding to the resident. RSR 19's room had a foul stench and light brown substances were noted on her sheets.

On 02/19/18, at 05:32 a.m., during an interview, CNA 1 stated call lights were the CNAs responsibility and that charge nurses (CN) had to answer call lights when the CNAS were busy. According to CNA 1, she did not see RSR 19's call light on.

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A review of the facility's policy, dated 11/16, titled, "Abuse Prevention Program," indicated the facility would ensure the health, safety and comfort of residents by preventing abuse and mistreatment. This policy indicated that neglect was the failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress.

F 755 SS=E Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) — F 755

§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate

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reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to follow and implement its policy and procedures and state requirements for controlled medications:

1. The Controlled Drug Record (individual patient's narcotic record) for discontinued medications had no dates and signatures of the DON and the pharmacy consultant when they were destroyed.

2. Controlled Drug Disposition Records were missing and not reviewed during medication reconciliation.

3. Methadone (narcotic medication, used to treat people who were addicted to heroin and narcotic pain medicines) was not given according to t he physician's order.

These deficient practices had the potential for misuse, abuse, or diversion of residents' medication throughout the facility for eight out of 12 residents' narcotic records reviewed.

Findings:

During inspection of the discontinued controlled medications on 2/19/2018, at 10:50 a.m., in the office of the Director of Nursing (DON), the following were observed:

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A. The controlled Drug Disposition Records were missing for the following medications:

1. Lyrica 25 milligram (mg) for two residents
2. Tramadol 50 mg for four residents
3. Norco 10- 325 mg for one resident
4. Methadone 10 mg for one resident (Resident 8)

B. Five narcotic count sheets for methadone did not have the dates and signatures of the DON and the pharmacy consultant when the methadone was discontinued. There was no documented evidence the DON and the pharmacy consultant did a reconciliation of the discontinued methadone medications.

C. The narcotic log had discrepancy on the date the medication was discontinued. The pharmacy consultant documented medications were destroyed 2/5/18 and the DON documented 1/5/2018.

D. A review of Resident 8's physician order, dated 10/22/2017, indicated methadone 10 mg, give two tablets (equals to 20 mgs) orally every eight hours for pain.

A review of Resident 8's Controlled Drug Record, indicated 2.5 mg of methadone was administered on 12/10/2017. There was no physician's order for methadone 2.5 mg.

A review of the facility's narcotic log, dated 12/11/2017, indicated methadone 0.5 1/4 tablet was administered to Resident 8.

On 2/19/2018, at 12 p. m., during an interview, the DON stated she and the pharmacy consultant

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destroyed the discontinued narcotics monthly. The DON had no comment when asked about the discrepancies on the dates on the narcotic logs and the facility's staff giving methadone without following the physician's order. The DON acknowledged she made a mistake in dating the narcotic log instead of dating 2/5/2018, she wrote 1/5/2018. When asked regarding the five narcotic count sheets for methadone without her signatures and the pharmacy consultant, the DON did not respond.

On 2/19/18, at 5:43 p.m., during a telephone interview, the pharmacy consultant stated he was at the facility on 2/5/2017, to destroy the discontinued narcotics. He stated he checked on the bubble packs (actual medications) and the count sheets (reconciliation of medications) and co-signed with the DON and then destroyed the discontinued narcotics by putting them into the pharmaceutical container. He stated when the medications were destroyed, the narcotic logs were then dated and the DON and he co-signed each sheet. When asked regarding the five narcotic count sheets for methadone without his signatures and the DON, he stated whatever narcotic count sheet that had his signatures, the medications were destroyed.

According to the facility's policy and procedures, "Preparation and General Guideline of Controlled Medication," dated 1/23/2015, indicated controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulation by the DON and the consultant pharmacist. Only DON and pharmacy personnel have access to destroy controlled medications.

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F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure medications or supplies that were removed from the emergency kit (E- KIT) indicated the staff's name, date and time, medication, number of dose (s), resident's name, and the physician's order. The facility failed to indicate the dates and years of five non-controlled medication logs that were destroyed.

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Findings:

a. On 2/19/2018, at 10:20 a.m., during an inspection of the medication room in Nursing Station I with Registered Nurse Supervisor 1 (RNS 1), an intravenous (IV, medications given directly through the vein) E-Kit was observed fastened with green zip ties on both sides of the E-kit. When asked, RNS 1 stated the green zip ties indicated the IV E-kit had been opened. When asked when, who, and what was taken from the IV E-Kit, RNS 1 stated he needed to see the record inside. RNS 1 opened the IV E-kit lid and the record had no documentation who opened, what was taken from it, what time and for which resident it was used. A review of the blank sheet indicated fill the facility's name, complete the form and fax it to "Premier and Pharmacy Services" for each and every dose taken from the E-kit.

On 2/19/2018, at 10:30 a. m., during an interview with RNS 1, he stated any medication that was taken from the IV E-kit had to be logged in the IV E-kit record with the date, time, the resident's name, what type of medication, physician's order, the staff name and to call the facility's pharmacy to replace the opened IV E-kit. RNS 1 stated it would be difficult to account for the medications if the IV E-kit record was not completed. RNS 1 confirmed there was no documented evidence indicating what was removed from the IV E-kit.

On 2/19/2018, at 3:57 p.m., during a telephone interview with RN 1 stated IV E-kit was opened by her on 2/17/2018, and Invanz (a type of antibiotic used to treat severe infections of the skin, lungs, stomach, pelvis, and urinary tract) 1 gram and a box of IV supplies were taken from the IV E-kit.

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F 761	Continued From page 60 RN 1 stated she failed to document on the record sheet. RN 1stated she failed for follow the facility's policy for E-kit. b. A review of five non-controlled medication logs that were destroyed had no dates and years these medications were destroyed. On 2/19/2018, at 12:45 p.m., during an interview with RNS 1, he stated staff should have indicated the date and the year when those medications were destroyed.	F 761		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 809		

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failed to offer bedtime snacks on the weekend for eight of eight alert and oriented residents that attended the group meeting. This deficient practice had the potential of resulting in the residents experiencing hunger between dinner and breakfast the following morning affecting the resident's quality of life.

Findings:

On February 18, 2018, at 3:29 p.m., during the group interview, eight of eight alert and oriented residents stated they were not offered bedtime snacks on the weekend.

During an interview with the dietary supervisor on February 18, 2018, at 5 p.m., she stated snacks were prepared for the residents on the weekend. However, there were no documentation that bedtime snacks were offered to the residents on the weekend.

During an interview with the director of nursing (DON) on February 18, 2018, at 5 p.m., stated she was not aware bedtime snacks were not offered to the residents on the weekend.

During an interview with the Administrator on February 18, 2018, at 5 p.m., stated she was not aware bedtime snacks were not offered to the residents on the weekend.

A review of the facility's policy, revised date January 1, 2012, titled, "Meals-Serving between meal nourishment", indicated the following:

1. In between meal, nourishment is given to provide the resident with extra nourishment and adequate nutrition. Check that all nourishment is

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F 809	Continued From page 62 on the tray before passing it to the resident. Report any missing items to the charge nurse. 2. Ensure that the right nourishment is served to the right resident.	F 809		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		

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(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility staff failed to practice infection control measures during care for two of 18 sampled residents (Resident 69 and 66).

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The facility failed to clean Resident 69's feces before performing wound care for pressure sore (injury to skin and underlying tissue resulting from prolonged pressure on the skin) to prevent cross contamination.

The facility staff failed to wash hands after contaminating hands and before putting on gloves, change gloves between each eye drop administration, and use different tissue to wipe the eyes for Resident 66.

These deficient practices had the potential to result in cross contamination and infections.

Findings:

a. A review of the admission records indicated Resident 69 was admitted to the facility on January 15, 2018, with diagnoses that included dementia (loss of memory and other mental abilities severe enough to interfere with daily life).

A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated January 22, 2018, indicated Resident 69 had the ability to make self-understood and usually understood others. The resident required extensive to total assistance from staff with all her activities of daily living.

During an observation on February 19, 2018, at 9:05 a.m., of Resident 69's pressure sore dressing change, Licensed Vocational Nurse 7 (LVN 7) and Certified Nurse Assistant 21 (CNA 21) while turning the resident to perform wound dressing change for the resident pressure sore, feces was observed in-between the resident

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buttocks however (LVN 7) continued to perform wound dressing change for the resident pressure sore without cleaning the feces from the area on the pressure sore.

During an interview with LVN 7 on February 19, 2018, at 9:45 a.m., after completing wound dressing change for Resident 69's pressure sore, she acknowledged feces in-between the residents buttocks and stated she did not see from her angle, however when surveyor switched places with LVN 7, feces could be seen in-between Resident 69's buttocks.

During an interview with CNA 21 on February 19, 2018, at 2:11 p.m., CNA 21 stated she cleaned the feces from in-between the resident buttocks after LVN 7 performed wound care for Resident 69's pressure sore.

b. On 2/17/2018, at 8:50 a.m., during the medication pass observation, Licensed Vocational Nurse 8 (LVN 8) prepared medications without washing her hands after she opened and closed the drawer of the medication cart and taking the medication cart keys from the pocket of her scrubs. LVN 8 pulled gloves from her scrub pocket and donned them, then administered dorzolamide hydroclide (HCL) 2 percent (%) one drop to Resident 66's right eye while standing on the right side of the bed then instilled one drop to the resident's left side of the eye without changing gloves between each eye. LVN 8 did not apply pressure to the lacrimal duct after each drop of the medication was administered. LVN 8 observed wiping both eyes with the same piece of tissue after administering the eye drop medication.

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A review of Resident 66's Admission Records indicated he was readmitted to the facility on 12/28/2018, with diagnoses that included but were not limited to Glaucoma (a condition of increased pressure within the eyeball, causing gradual loss of sight).

A review of Resident 66's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/16/2018, indicated the resident's cognitive skills (set of mental abilities or processes) for daily decision making were impaired, was totally dependent on the staff with activities of daily living. MDS Section B1000 (vision) indicated Resident 66 had moderately impaired vision, not able to see newspaper headline but can identify objects.

A review of Resident 66's physician's order summary, dated 2/2018, indicated dorzolamide HCL 2 % eye drops, instill one drop to both eyes three times a day for Glaucoma.

A review of the Resident 66's care plan titled, "Potential for injury due to impaired visual fluctuation secondary to Glaucoma," dated 12/28/2017, goals included for the resident will have no injury in the next three months. Interventions included to maintain hazard and safe free environment, monitor for eye pain/problem, notify physician promptly, and administer medication as ordered.

On 2/17/18, at 3:14 p.m., during an interview, LVN 8 stated she forgot to wash her hands and and change gloves between each eye drop. LVN 8 stated she did not apply pressure to resident's lacrimal duct area after each drop. When asked, LVN 8 stated she did know the rationale for the

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	555677	A. BUILDING _____ B. WING _____	02/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE HEALTHCARE & WELLNESS CENTRE, LP	11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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application of pressure to the area and the reason why the eye drop was given.

F 917 SS=E Resident Room Bed/Furniture/Closet
CFR(s): 483.10(i)(4), 483.90(e)(2)(3) — F 917

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv)

§483.90(e)(2) -The facility must provide each resident with--
(i) A separate bed of proper size and height for the safety and convenience of the resident;
(ii) A clean, comfortable mattress;
(iii) Bedding, appropriate to the weather and climate; and
(iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

§483.90(e)(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (e)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations
(i) Are in accordance with the special needs of the residents; and
(ii) Will not adversely affect residents' health and safety.
This REQUIREMENT is not met as evidenced by:
Based on observation and interviews, the facility failed to provide comfortable mattresses. There were four sunken mattresses observed (Rooms 5B, 12A, 21B and 32C). This deficient practice had the potential for the residents not attaining

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highest practicable well-being.

Findings:

On February 18, 2018, at 10 a.m., during a tour of the facility with the Maintenance Supervisor (MS), there were sunken mattresses in Rooms 5B, 12A, 21B and 32C.

A review of the facility's policy and procedures, revised date of January 1, 2012, titled, "Resident rooms and environment," indicated the following:

1. To provide residents with a safe, clean, comfortable and homelike environment.
2. The facility provides residents with a safe clean comfortable and homelike environment. Facility staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents comfort, independence, and personal needs and preferences.

F 919 SS=E — Resident Call System — CFR(s): 483.90(g)(2) — F 919

§483.90(g) Resident Call System
The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.

§483.90(g)(2) Toilet and bathing facilities.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure call lights were functioning (Rooms 3, 7, 9, 12 and 19). These

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deficient practices resulted in residents' needs not met timely and had a potential to result in falls and skin injuries.

Findings:

A review of RSR 19's Admission Face Sheet indicated the resident was admitted to the facility on 2/16/18 with diagnoses including end stage renal disease ([ESRD] kidney disease) and diabetes.

A review of RSR 19's care plan, dated 2/17/18, indicated the resident required assistance with bed mobility, walking, dressing, transfer, toilet use and personal hygiene. The intervention of this care plan indicated the staff would provide assistance with ADLs, turn, and reposition the resident as needed.

On 02/19/18, at 05:15 a.m., during an observation, RSR 19's call light was on but not ringing at the Nurse's Station.

On 02/19/18, at 05:25 a.m., RSR 19 was observed yelling "senorita" (miss in Spanish), and a certified nursing assistant (CNA 1) was observed walking by the room without responding to the resident. RSR 19's room had a foul stench and light brown substances were noted on her sheets.

On 02/19/18, at 05:29 a.m., during a concurrent observation and interview, the facility's maintenance supervisor (MS) stated that RSR 19's call light was on but not ringing and not lighting at the call system located in the Nurse's Station. According to MS, the bulb was blown. The MS stated that the call system was checked

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every month.

On 02/19/18, at 05:32 a.m., during an interview, CNA 1 stated call lights were the CNAs responsibility and that charge nurses (CN) had to answer call lights when the CNAS were busy. According to CNA 1, she did not see RSR 19's call light on.

On 2/19/18, at 8:10 a.m., during a concurrent observation and interview, the call lights in Rooms 3, 7, 9, 12 and 19 were not working and the MS stated the bulbs were blown and that he would have them replaced. The call system at the Nurse's Station had tapes on Rooms 1, 6, 11, 16, 17 and 22. According to the MS, the system was old and the ring holding the numbers in place were broken. The MS added that he had to use glue on the inner aspect of the call system to hold the broken room numbers in place.

A review of the facility's policy, dated 1/1/12, titled, "Communication Call System," indicated the facility would provide a call system to enable residents to alert the nursing staff from their rooms.