POC Accepted on 4/22/2024 By TCam

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056180	A. BUILDING _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE BALBOA CARE CENTER	16955 VANOWEN STREET VAN NUYS, CA 91406

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the Recertification Survey conducted on 3/21/2024. Representing the Department of Public Health: Surveyor ID No. 38549, Health Facilities Evaluator Nurse Surveyor ID No. 38469, Health Facilities Evaluator Nurse Surveyor ID No. 48142, Health Facilities Evaluator Nurse Facility Census: 48 Resident Sample Size: 14 Highest Severity and Scope: E	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X8) DATE 4/10/24

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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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure Certified Nurse Assistant 1 (CNA 1) knocked and asked permission prior to entering two of two sampled residents' rooms (Resident 98 and 28). This deficient practice had the potential to affect the residents' sense of self-worth and self-esteem. Findings: During a concurrent observation and interview on 3/17/2024 at 11:27 a.m., observed CNA 1 walking in the hallway and went inside Resident 98's room without knocking and asking permission. Observed CNA 1 exit Resident 98's room and	F 550		

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F 550	Continued From page 2 proceeded to go inside Resident 28's room without knocking and asking permission. Upon exiting Resident 28's room, CNA 1 was asked how the facility promotes and ensures dignity and respect for the resident's private space such as when accessing their rooms. CNA 1 replied that prior to entering a resident's room, staff should knock, introduce themselves and ask permission to come into the resident's room. CNA 1 stated that they periodically receive in-services (training intended for those actively engaged in a profession) regarding respecting resident's rights which included their right to a dignified existence and knocking and asking permission prior to entering their rooms as a way to promote their dignity. CNA 1 acknowledged by stating that she did not knock and ask permission from the residents when she went into Resident 98's and Resident 28's room. A review of the facility's policy and procedure titled, "Resident Rights," last reviewed on 1/2024, indicated, "Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the Resident from passers-by. People not involved in the care of the Resident shall not be present without the resident's consent while they are being examined or treated. Staff members shall knock before entering the Resident's room ..."	F 550		
F 558 SS=D	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	F 558		

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F 558	Continued From page 3 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 that a resident's call light (a remote control that allows patients to request assistance from nurses or other staff) was within reach for one of one sampled resident (Resident 150) investigated under the care area of accommodation of needs. This deficient practice had the potential to cause a delay in resident care and for the residents' needs to remain unmet. Findings: A review of Resident 150's Admission Record indicated the facility admitted the resident on 3/15/2024 with diagnoses including pneumonia (an infection that affects one or both lungs) and unspecified fall. A review of Resident 150's History and Physical (a formal document that a physician produces through a patient interview, physical exam, and summary of any testing), dated 3/17/2024, indicated the resident has fluctuating (to vary or change irregularly) capacity to understand and make decisions. A review of Resident 150's Care Plan (a written document that outlines a patient's needs, goals, and the steps to address them) for risk for falls, initiated on 3/15/2024, indicated that the resident will be free of falls through the review date and will not sustain serious injury through the review date. An intervention included to ensure the call	F 558		

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F 558	Continued From page 4 light is within reach and encourage the resident to use the call light for assistance as needed. During an observation on 3/18/2024 at 9:50 a.m., observed Resident 150 in bed with their call light under the bed. During a concurrent observation and interview on 3/18/2024 at 9:55 a.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 verified the observation by stating that Resident 150's call light was under the bed. CNA 2 stated the call light should have been within the resident's reach, so he could call for help when needed. During an interview on 3/21/2024 at 9:59 a.m., with the Director of Nursing (DON), the DON stated that call lights should always be within residents' reach. The DON stated they should be clipped to the resident's sheets. The DON stated it was important for call lights to be within reach so that residents can call for help in case of an emergency. The DON stated if residents were unable to use their call light, there can be a potential risk of an accident occurring. A review of the facility's policy and procedure titled, "Call Light," last reviewed on 1/2023, indicated it is the policy of the facility to provide the resident a means of communication with nursing staff. Place the call device within resident's reach before leaving room.	F 558		
F 578 SS=D	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	F 578		

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F 578	Continued From page 5 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 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	F 578		

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failed to ensure a copy of the resident's Advance Directive (AD- a written statement of a person's wishes regarding medical treatment) is kept in the resident's chart and easily retrievable for one of five sampled residents (Resident 7) investigated for advance directive.

This deficient practice has the potential to create confusion which could lead to conflict with the resident's wishes regarding his/her health care.

Findings:

A review of Resident 7's Admission Record indicated the facility admitted the resident on 1/18/2024 with diagnoses that included gastro-esophageal reflux disease (stomach contents flow backward, up into the esophagus, the tube that carries food from your throat into stomach) and chronic kidney disease (gradual loss of kidney function).

A review of Resident 7's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 1/24/2024, indicated that Resident 7 had the ability to make self-understood and had the ability to understand others.

During a concurrent interview and record review on 3/20/2024 at 2:46 p.m., with the Director of Nursing (DON), reviewed Resident 7's Social Services Assessment/Evaluation dated 1/19/2024 and Resident 7's electronic chart and physical chart in regards for Resident 7's AD. Resident 7's Social Services Assessment/Evaluation dated 1/19/2024, indicated Resident 7 had issued an advance directive about her care and treatment with a note that indicated, "Obtain a copy of such directives to be included in the resident's medical

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F 578	Continued From page 7 record." The DON was not able to locate from the physical chart and electronic chart the actual copy of Resident 7's AD. The DON stated that if there is an existing AD, it should be kept in the physical chart so it can be referenced in case of an emergency because without it, the resident's wishes for health care treatment may not be followed or treatment provided may conflict with the resident's wishes. A review of the facility's policy and procedure titled, "Advance Directive," last reviewed on 12/2023, indicated, "It is the policy of the facility that a resident's choice about advance directives will be recognized and respected. Further, the facility recognizes and respects the resident's rights to choose their treatment and make decisions about care to be received at the end of their life ...obtain copy of the Advance Directive and conservatorship/guardianship documents and place in the resident health record ..."	F 578		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §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.	F 755		

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F 755	Continued From page 8 §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 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: 1. Ensure licensed nurses held (did not give) a resident's blood pressure (the force of blood pushing against the walls of the arteries) medications when the resident's blood pressure was outside of the physician's prescribed parameters (a set of defined limits) for one of one sampled resident (Resident 39) investigated under pharmacy services. This deficient practice had the potential to place the resident at increased risk of adverse side effects (undesired harmful effect resulting from a medication or other intervention). 2. Ensure the 9:00 p.m. dose of cefepime (antibiotic- it can treat bacterial infections) was administered on 2/16/2024 per physician's orders	F 755		

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F 755	Continued From page 9 for one of one sampled resident (Resident 20) investigated under Antibiotic Use. This deficient practice placed the resident at risk for unintended complication of not completing the entire antibiotic course that could lead to antibiotic or antimicrobial resistance (antimicrobial resistance happens when germs develop the ability to defeat the drugs designed to kill them and continue to grow). Findings: 1. A review of Resident 39's Admission Record indicated the facility admitted the resident on 2/5/2024 with diagnoses including hypertensive chronic kidney disease (a condition that occurs when high blood pressure [the force of the blood pushing on the blood vessel walls is too high] damages the kidneys). A review of Resident 39's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/8/2024, indicated the resident had severely impaired cognition (a term for the mental processes that take place in the brain) and was dependent on staff for toileting hygiene, showering/bathing, dressing, bed mobility, and transferring. A review of Resident 39's physician's orders indicated the following: - Metoprolol tartrate (medication used for high blood pressure) 50 milligrams (mg - unit of measurement). Give one tablet by mouth two times a day related to essential (primary) hypertension (high blood pressure) with food, hold for systolic blood pressure (SBP - the first number in a blood pressure reading, which	F 755		

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measures the pressure in the arteries when the heart beats) less than 110 millimeters of mercury (mmHg - unit of measurement) and pulse less than 60 beats per minute (BPM - unit of measurement), ordered on 2/5/2024.
- Nifedipine (medication used for high blood pressure) extended release (ER - designed to last longer in the body) 30 mg. Give one tablet by mouth two times a day for hypertension, hold for SBP less than 110 mmHg, ordered on 2/5/2024.

A review of Resident 39's Care Plan (a written document that outlines a patient's needs, goals, and the steps to address them) for risk for high blood pressure level related to hypertension, initiated on 2/6/2024, indicated an intervention to give anti-hypertensive medications as ordered.

During a concurrent interview and record review on 3/21/2024 at 10:01 a.m., with the Director of Nursing (DON), reviewed Resident 39's Medication Administration Record (MAR - a report detailing the drugs administered to a patient by a healthcare professional) dated 2/2024. The DON verified by stating the following:
- On 2/10/2024 at 9 a.m., the licensed nurse administered metoprolol 50 mg when Resident 39's blood pressure was 107/66 mmHg.
- On 2/10/2024 at 9 a.m., the licensed nurse administered nifedipine 30 mg when Resident 39's blood pressure was 107/66 mmHg.
- On 2/28/2024 at 9 a.m., the licensed nurse administered metoprolol 50 mg when Resident 39's blood pressure was 100/60 mmHg.
- On 2/28/2024 at 9 a.m., the licensed nurse administered nifedipine 30 mg when Resident 39's blood pressure was 100/60 mmHg.
The DON stated that based on Resident 39's blood pressure parameters, metoprolol and

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nifedipine should not have been administered. The DON stated that if the resident already had low blood pressure, then giving them anti-hypertensive medications can cause the resident to experience increased hypotension (low blood pressure).

A review of the facility's policy and procedure titled, "Medication Administration," last reviewed on 1/2024, indicated it is the facility's policy to accurately prepare, administer, and document oral medications. Take vital signs if required. Hold drugs if indicated.

2. A review of Resident 20's Admission Record indicated the facility admitted the resident on 2/6/2024 with diagnoses including hypertension and type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]).

A review of Resident 20's MDS dated 2/9/2024, indicated the resident's cognitive skills for daily decision-making was moderately impaired. The MDS further indicated Resident 20 required partial/moderate assistance with toileting hygiene, shower, lower body dressing and putting on and taking off footwear.

A review of Resident 20's physician's order dated 2/6/2024, indicated an order for cefepime hydrochloride injection solution reconstituted one (1) gram (gm- a unit of measurement) intravenously (usually refers to a way of giving a drug or other substance through a needle or tube inserted into a vein) every 12 hours for urinary tract infection (an infection in any part of the urinary tract, the system of organs that makes urine) until 3/12/2024.

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F 755	Continued From page 12 During a concurrent interview and record review on 3/20/2024 at 3:20 p.m., with the Director of Nursing (DON), reviewed Resident 20's MAR for the month of 2/2024. Resident 20's MAR dated 2/2024 indicated that the cefepime 1 gm intravenous dose for 2/16/2024 at 9:00 p.m. was not documented as given. The DON stated that if the medication dose is not documented that means it was not given. The DON stated that a complication of not completing the antibiotic course can result to an untreated infection. The DON stated that untreated infection will require more antibiotic doses which could result to antibiotic resistance making the infection hard to treat. A review of the facility's policy and procedure titled, "Nursing Services," last reviewed on 1/2024, indicated, "It is the policy of this facility that medications and/or fluids shall be administered as prescribed by the attending physician ..."	F 755		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		

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F 812	Continued From page 13 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow proper food handling practices by failing to ensure a bag of raw beef located in one of two facility refrigerators (Refrigerator 1) was labeled and dated when taken out of the freezer and placed in the refrigerator to be thawed. This deficient practice had the potential to place 46 out of 48 residents living in the facility at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: During an observation of the facility's kitchen and concurrent interview on 3/18/2024 at 8:11 a.m., with the Dietary Supervisor (DS), observed one transparent plastic bag containing a slab of raw beef inside Refrigerator 1. Upon closer inspection, the slab of raw beef did not have a date as to when it was placed in the refrigerator for thawing. The DS stated that if there is no date on the meat item placed in the refrigerator for thawing, the kitchen staff will not know when the meat item was pulled out from the freezer. The DS stated that meat items that have no thawing dates are not safe to be consumed by the residents and if ingested could result to foodborne illnesses.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056180	A. BUILDING _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE BALBOA CARE CENTER	16955 VANOWEN STREET VAN NUYS, CA 91406

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F 812	Continued From page 14 A review of the facility's policy and procedure titled, "Food Storage," last revised on 8/29/2023, indicated, "Thawing: Thaw meat preferably by placing in deep pans and setting on lowest shelf in refrigerator. Develop guidelines detailing defrosting procedure for different types of food. Date meat when taken out of freezer. Follow meat pull schedule when available in menu program ..."	F 812		
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to meet the required room size of 80 square feet (sq ft - unit of measurement) per resident for 10 of 23 multiple resident rooms (Room 101, 103, 105, 107, 110, 112, 115, 117, 119, and 121). This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the residents. Findings: During the resident council (a group of nursing home residents who meet regularly to discuss their rights, quality of care, and quality of life) meeting on 3/18/2024 at 2:31 p.m., when the residents were asked about their room space, there were no concerns or issues brought up.	F 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056180	A. BUILDING _____ B. WING _____	03/21/2024

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F 912	Continued From page 15	F 912		

During the recertification survey from 3/18/2024 to 3/21/2024, observed that the residents residing in the rooms with an application for variance had sufficient amount of space for residents to move freely inside the rooms. There was adequate room for the operation and use of wheelchairs, walkers, and canes. The room variance did not affect the care and services provided by nursing staff to the residents.

On 3/18/2024, the Administrator (ADM) submitted the "Client Accommodation Analysis" and a letter requesting for continuation of their room waiver. A review of the "Client Accommodation Analysis" indicated that 10 out of 23 resident rooms did not have at least 80 square feet per resident. The room waiver request and Client Accommodation Analysis showed the following:

Room No.	Square Footage	Bed Capacity	Sq. Ft. per Resident
101	151.55	2	75.78
103	153.67	2	76.84
105	159.30	2	79.65
107	155.58	2	77.79
110	310.66	4	77.67
112	312.05	4	78.01
115	156.48	2	78.24
117	153.67	2	76.84
119	157.60	2	78.80
121	154.68	2	77.34

The minimum requirement for a 2-bedroom should be at least 160 sq. ft.

The minimum requirement for a 4-bedroom should be at least 320 sq. ft.

A review of the room waiver letter, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056180	A. BUILDING _____ B. WING _____	03/21/2024

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F 912	Continued From page 16 3/18/2024, indicated, "No patients in these rooms are hindered, nor adversely affected by the limited room size. There is adequate room for the operation and use of wheelchairs, walkers, and other like aides. All of the following are available to each patient: they all have sufficient closet, drawer, and storage space. Bathrooms are easily accessible to all patients. The rooms are close to the nursing stations and exit doors. This makes it very accessible to the evacuation areas. The rooms are well-lit and aerated. A denial of this waiver would cause a severe financial hardship, which would jeopardize the continued operation of this facility. After careful evaluation of this facility's building plan, the Quality Assurance Committee has reached the conclusion that the waiver on room size will not in any way threaten the health, safety, or happiness of any of the patients." A review of the facility's policy and procedure titled, "Resident Rooms," last reviewed on 1/2024, indicated it is the policy of this facility that a resident room must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in a single resident room.	F 912		

FTAG 550

Corrective action(s) accomplished for those residents found to have been affected by this alleged statement of deficient practice:

1. CNA 1 was provided a one-on-one verbal in-service education on March 17, 2024, by Director of Staff Development regarding the facility policy that all residents be treated with respect and dignity and staff members shall knock before entering the resident's room. Resident 98 and 28 overall status was not affected by the deficient practice after being assessed.

2. Director of Staff Development and / or Director of Nursing Services conducted an in-service education to staff on March 19, 2024, March 27, 2024, and April 08, 2024, respectively regarding strict adherence to the facility policy on resident rights that all residents must be treated with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, and staff members shall knock before entering the resident's room.

Corrective action for other residents found to have been affected by the same deficiency:

1. No other residents were found to be affected with the deficient practice after assessment on March 17, 2024.

Systemic revisions completed by the facility to decrease risks for recurrence of alleged statement of deficient practice.

1. The above in-service education will be included in the orientation of the newly hired Licensed nurses and CNA and will be repeated as deemed necessary by the Director of Staff Development and / or designee.

2. Director of Staff Development and / or designee will observe randomly compliance of CNA and Licensed Nurses that all residents must be treated with respect and dignity and staff shall knock before entering the resident's room.

3. Director of Staff Development and / or designee will observe randomly on a weekly basis to ensure compliance by Licensed nurses and CNA and will report nonadherence of staff to the Director of Nursing Services and / or designee for further re-education and disciplinary action as appropriate.

Facility plans to ensure alleged deficient practice correction is achieved, sustained, evaluated for effectiveness and integrated into the QAPI program.

1. Director of Staff Development and / or designee will be responsible to report all findings to QA&A committee monthly times three on the status of ongoing compliance. The QA&A committee shall determine agenda for further revision and /or revision to plan of correction.

2. The Administrator / and or designee is responsible in ensuring compliance is achieved and sustained.

Date of completion: April 10, 2024

FTAG 558

Corrective action(s) accomplished for those residents found to have been affected by this alleged statement of deficient practice:

1. Resident 150 was assessed immediately on March 18, 2024, and placed the call light within reach before leaving the room. CNA 2 was provided a one-on-one verbal in-service education on March 18, 2024, by Director of Staff Development regarding the facility policy to provide the resident a means of communication with nursing staff and place the call light within resident's reach before leaving the room.

2. Director of Staff Development and / or Director of Nursing Services conducted an in-service education to staff on March 19, 2024, March 27, 2024, and April 08, 2024, respectively regarding strict adherence to the facility policy to provide the resident a means of communication with nursing staff which is a call light and must be place within resident's reach before leaving the room.

Corrective action for other residents found to have been affected by the same deficiency:

1. No other residents were found to be affected with the deficient practice after assessment on March 18, 2024.

Systemic revisions completed by the facility to decrease risks for recurrence of alleged statement of deficient practice.

1. The above in-service education will be included in the orientation of the newly hired Licensed nurses and CNA and will be repeated as deemed necessary by the Director of Staff Development and / or designee.

2. Director of Staff Development and / or designee will observe randomly compliance of CNA and Licensed Nurses that all resident's call light within reach before leaving the room and reminded resident to use the call light to communicate with nursing staff for any needs.

3. Director of Staff Development and / or designee will observe randomly on a weekly basis to ensure compliance by Licensed nurses and CNA and will report nonadherence of staff to the Director of Nursing Services and / or designee for further re-education and disciplinary action as appropriate.

Facility plans to ensure alleged deficient practice correction is achieved, sustained, evaluated for effectiveness and integrated into the QAPI program.

1. Director of Staff Development and / or designee will be responsible to report all findings to QA&A committee monthly times three on the status of ongoing compliance. The QA&A committee shall determine agenda for further revision and /or revision to plan of correction.

2. The Administrator / and or designee is responsible in ensuring compliance is achieved and sustained.

Date of completion: April 10, 2024

FTAG 578

Corrective action(s) accomplished for those residents found to have been affected by this alleged statement of deficient practice:

1. Social Services Director and assistant was provided in-service education on March 20, 2024, by the Director of Nursing Services regarding facility policy on Advanced Directives to obtain a copy and place in the resident's health record. On March 20,2024, Social Service provided Resident 7 with written information regarding advanced directive and Social Services Assessment/Evaluation was completed.

2. Director of Nursing Services conducted an in-service education to Social Services on March 20, 2024, March 25, 2024 and April 08, 2024 respectively regarding facility policy on Advanced Directives that a resident's choice will be recognized and respected; the facility recognizes and respects the resident's right to choose their treatment and make decision about care to be received at the end of their life; obtain copy of Advance Directives and conservatorship/guardianship documents and place in the resident health record.

Corrective action for other residents found to have been affected by the same deficiency:

1. No other residents were found to be affected by the deficient practice on March 20, 2024.

Systemic revisions completed by the facility to decrease risks for recurrence of alleged statement of deficient practice.

1. The above in-service education will be included in the orientation of the newly hired Social Service, full time or part time, and the Social Service Assistant and will be repeated as deemed necessary by the Director of Staff Development and / or designee.

2. Director of Medical Records and / or designee will conduct audit after each admission on a weekly basis to ensure compliance of Social Services on Advance Directive to obtain a copy and place in the resident's health record.

3. Director of Medical Records and / or designee will conduct audit after each admission on a weekly basis to ensure compliance of Social Services and will report nonadherence of Social Services Department to the Director of Nursing Services and / or designee for further re-education and disciplinary action as appropriate.

Facility plans to ensure alleged deficient practice correction is achieved, sustained, evaluated for effectiveness and integrated into the QAPI program.

1. Director of Medical Records and / or designee will be responsible to report all findings to QA&A committee monthly times three on the status of ongoing compliance. The QA&A committee shall determine agenda for further revision and /or revision to plan of correction.

2. The Administrator / and or designee is responsible in ensuring compliance is achieved and sustained.

Date of completion: April 10, 2024

FTAG 755

Corrective action(s) accomplished for those residents found to have been affected by this alleged statement of deficient practice:

1. Licensed Nurses was provided an in-service education on March 20, 2024, by Director of Nursing Services regarding the facility policy to accurately prepare, administer, and document oral medications, take vital signs if required, hold drugs if indicated. Medications and/or fluids shall be administered as prescribed by the attending physician and medications must be administered in accordance with the written orders of the attending physician following parameter indicated on the order prior to medication administration. Resident 39 was assessed, and vital signs was checked on March 20, 2024, not affected by the deficient practice. Reviewed and ensured resident medication order and parameter is being followed accordingly prior to medication administration.

2. Registered Nurses was provided an in-service education on March 20, 2024, by Director of Nursing Services regarding the facility policy that medications and/or fluids shall be administered as prescribed by the attending physician and current drugs and dosage schedules must be documented on the resident's electronic medication administration record (EMAR). Resident 20 was assessed on March 20, 2024, not affected by the deficient practice. Reviewed and ensured resident medication order drug and dosage schedule is being administered timely and documented on the resident 's electronic medication administration record (EMAR).

3. Director of Nursing Services and / or designee conducted an in-service education to licensed nurses on March 20, 2024, March 25, 2024, and April 09, 2024 respectively regarding strict adherence to the facility policy to accurately prepare, administer, and document oral medications, take vital signs if required, hold drugs if indicated, medications and/or fluids shall be administered as prescribed by the attending physician and medications must be administered in accordance with the written orders of the attending physician following parameter indicated on the order prior to medication administration and resident medication order drug and dosage schedule is being administered timely and documented on the resident 's electronic medication administration record (EMAR).

Corrective action for other residents found to have been affected by the same deficiency:

1. No other residents were found to be affected with the deficient practice after assessment on March 20, 2024.

Systemic revisions completed by the facility to decrease risks for recurrence of alleged statement of deficient practice.

1. The above in-service education will be included in the orientation of the newly hired Licensed nurses and will be repeated as deemed necessary by the Director of Nursing Services and / or designee.

2. Medical Records Director and / or designee will conduct weekly audit for compliance of Licensed Nurses regarding the facility policy that medications and/or fluids shall be administered as prescribed by the attending physician and medications must be administered in accordance with the written orders of the attending physician following parameter indicated on the order prior to medication administration and resident medication order drug and dosage schedule is being administered timely and recorded on the resident 's electronic medication administration record (EMAR).

3. Medical Records Director and / or designee will conduct audit to ensure compliance of Licensed Nurses on a weekly basis. Medical Records Director and / or designee will report nonadherence of Licensed Nurses to the Director of Nursing Services for further re-education and disciplinary action as appropriate.

Facility plans to ensure alleged deficient practice correction is achieved, sustained, evaluated for effectiveness and integrated into the QAPI program.

1. Director of Nursing Services and / or designee will be responsible to report all findings to QA&A committee monthly times three on the status of ongoing compliance. The QA&A committee shall determine agenda for further revision and /or revision to plan of correction.

2. The Administrator / and or designee is responsible in ensuring compliance is achieved and sustained.

Date of completion: April 10, 2024

FTAG 812

Corrective action(s) accomplished for those residents found to have been affected by this alleged statement of deficient practice:

1. Dietary Supervisor immediately discarded the raw beef that was found not labeled and dated. On March 21, 2024, Dietary Supervisor provided in service education with dietary staff regarding the proper procedure for labeling thawing meat.

2. Dietary Supervisor and / or designee conducted an in-service education to dietary staff on March 21, 2024, and April 09, 2024 respectively regarding strict adherence to the facility policy on thawing meat preferably by placing in a deep pan and setting on lowest shelf in refrigerator; following guidelines detailing defrosting procedure for different types of food; date meat when taken out of freezer; and follow pull meat schedule when available in menu program.

Corrective action for other residents found to have been affected by the same deficiency:

1. No residents were found to be affected with the deficient practice after assessment on March 18, 2024.

2. Dietary Supervisor and / or designee will observe and check completion daily of each facility refrigerator for correct Pull by date, "meat pull" sign off sheet posted on facility's refrigerator and "refrigerated audit log".

Systemic revisions completed by the facility to decrease risks for recurrence of alleged statement of deficient practice.

1. The above in-service education will be included in the orientation of the newly hired dietary staff and will be repeated as deemed necessary by the Dietary Supervisor and / or designee.

2. Dietary Supervisor and / or designee will conduct audit on a weekly basis to ensure compliance of dietary staff and will report nonadherence of dietary staff to the Administrator and / or designee for further re-education and disciplinary action as appropriate.

Facility plans to ensure alleged deficient practice correction is achieved, sustained, evaluated for effectiveness and integrated into the QAPI program.

1. Dietary Supervisor and / or designee will be responsible to report all findings to QA&A committee monthly times three on the status of ongoing compliance. The QA&A committee shall determine agenda for further revision and /or revision to plan of correction.

2. The Administrator / and or designee is responsible in ensuring compliance is achieved and sustained.

Date of completion: April 10, 204