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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056489	A. BUILDING ______ B. WING ______	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLYWOOD PREMIER HEALTHCARE CENTER	**5401 FOUNTAIN AVE. LOS ANGELES, CA 90029**

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health (Department) during an annual recertification survey on 7/25/2024. In addition, the following represents the findings found during investigation of one Facility Reported Incidents (FRIs) numbered CA00909562. No deficiency was issued for FRI: CA00909562 Facility Census: 86 Resident Sample Size: 42 Highest scope and severity: E	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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.	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE DON | (X6) DATE 8/8/24

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 584	Continued From page 1 §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 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, interview, and record review the facility failed to maintain a safe and home like environment for one of two sampled residents (Residents 14) by not maintaining and repairing a damaged residents' floor surface. This failure had the potential for unsafe resident`s environment and placed the resident and staff at risk for fall hazard resulting in injury. Findings: During the survey initial tour observation on 7/22/2024 at 9:52 AM, Resident 14 room (room 124) was observed with the following: a. The floor surface appeared to be made of vinyl flooring.	F 584		

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F 584	Continued From page 2	F 584		

b.There was a crack and chip across the entire floor length from entrance to the back wall.
c. Uneven and slanted surface approximately by half inch.
d.Approximately a third of the room's floor surface alongside the cracked and chipped line was slanted.

During an interview on 7/22/2024 at 9:52 AM, Resident 14 stated that he has been in this room for the last few months and the damaged floor surface had been there since his admission in the room. Resident 14 stated that he does not like his room nor the facility and would like to transfer closer to his family and his hometown.

During an interview on 7/23/2024 at 2:23 PM with Certified Nursing Assistant 1 (CNA 1), CNA 1 was shown room 124 damage, CNA 1 stated she assists the residents in room 124 with ADLs, and the damaged floor has a potential risk for trip and fall for residents and staff. CNA 1 stated the damages on the floor has been there for several months and she had to watch her steps not to trip and fall.

During an interview on 7/23/2024 at 2:30 PM, with Director of Staff Development (DSD), the DSD was shown and confirmed the damaged floor in room 124. The DSD stated the damage needs to be repaired because it is a potential risk for fall.

During an interview on 7/25/2024 at 8:38 AM, in room 124 with the facility Environment Aide (EA), EA stated he has been working in the facility for over six years. EA stated the floor damage has been there for more than six months. EA stated the floor damage is not safe to walk in the room because it is a potential risk for fall.

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F 584	Continued From page 3 During an interview on 7/23/2024 at 2:45 PM with the Director of Maintenance and Housekeeping (DM) in front of room 124, DM stated the damages in room 124 were notified to facility leadership. DM stated that he had contacted a third-party company for repairs, and the repairs should be done soon. DM stated he had noticed the damages in room 124 for months and are potential for trip and fall. During an interview on 7/24/2024 at 11:35 AM with the facility`s Director of Nursing (DON), the DON stated there is a plan to repair the damaged floor in room 124. The DON stated we have transferred Resident 14 to a different room for the planned repair. The DON was unable to provide specific time frame and details of planned repair. A review of the facility's policy and procedure titled "Homelike Environment" not dated, indicated, "Resident are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximize, to the extent possible, that characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean sanitary and orderly environment."	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		

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F 656	Continued From page 4 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 656		

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F 656	Continued From page 5 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to create a care plan for Diflucan (Fluconazole, a medication that treats and prevents fungal infections) for one of six sampled residents (Resident 83). This deficient practice had the potential for Resident 83 to not have their needs met and receive inadequate care. Findings: A review of Resident 83's Admission Record indicated the resident was initially admitted to the facility on 5/28/2024 and re-admitted on 7/9/2024 with diagnoses that included an elevated white blood cell count (an increase in cells in the blood that fight infections), adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability), and urinary tract infection (UTI, an illness in any part of the urinary tract, the system of organs that makes urine). A review of Resident 83's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 6/4/2024, indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated the resident required supervision or touching assistance for eating and oral hygiene. The MDS further indicated the resident required substantial/maximal assistance for showering/bathing self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene.	F 656		

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F 656	Continued From page 6	F 656		

A review of Resident 83's physician order dated 7/16/2024, indicated the resident was to receive Diflucan 100 milligrams (mg) by mouth once a day for fungal pneumonitis (a lung infection caused by fungus). A review of Resident 83's care plan indicated the resident did not have a care plan for Diflucan.

During a concurrent interview and record review on 7/25/2024 at 11:45 AM, Resident 83's care plan was reviewed with the Director of Nursing (DON). The DON stated Resident 83 received Diflucan as ordered by the physician. The DON stated Resident 83 did not have a care plan for Diflucan. The DON stated Resident 83 should have a care plan for Diflucan. The DON stated a care plan was important to evaluate the effectiveness of antibiotics and to ensure that Resident 83 was not given unnecessary medication. The DON further stated the care plan should be updated when a new physician order is received. The DON stated resident needs could potentially not be met if the care plan is not developed.

A review of the facility's policy and procedure titled "Care Plans, Comprehensive Person-Centered" revised 3/2022, indicated "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The Interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops, and implements a comprehensive, person-centered care plan for each resident ...The care plan interventions are derived from a thorough

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F 656	Continued From page 7 analysis of the information gathered as part of the comprehensive assessment ...The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; any specialized services to be provided as a result of PASSAR recommendations; and which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflect currently recognized standards of practice for problem areas and conditions".	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		

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F 657	Continued From page 8 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to revise the care plan (a document outlining a detailed approach to care customized to an individual resident's need) for two of six sampled residents (Resident 33 and Resident 83) as evidenced by: 1. Failing to update the tube feeding (TF, a form of nutrition that is delivered into the digestive system as a liquid) care plan for Resident 33 to reflect current physician orders. 2. Failing to update the antibiotic (medicines that help stop infections caused by bacteria) care plan for Resident 83 to reflect current physician orders. These deficient practices had the potential for Resident 33 and Resident 83 to not have their needs met and receive inadequate care. Findings: 1. A review of Resident 33's Admission Record indicated the resident was admitted to the facility	F 657		

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F 657	Continued From page 9 on 3/20/2024 with diagnoses that included gastrostomy (G-Tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach), dysphagia (difficulty swallowing), and chronic gastritis (inflammation of the lining of the stomach) with bleeding. A review of Resident 33's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 6/25/2024, indicated the resident had severely impaired cognitive skills for daily decision making (never/rarely made decisions). The MDS indicated Resident 33 was dependent on help for eating. The MDS further indicated Resident 33 had a feeding tube (G-tube). A review of Resident 33's care plan revised on 6/25/2024, indicated the resident had altered nutrition and was receiving g-tube feeding Novasource 2.0 (a type of tube feeding that that provide nutritional needs for residents with elevated nutritional needs) at 40 milliliters (ml)/hour (hr.). The care plan had goals that included to minimize the risk of significant weight loss. The care plan indicated interventions that included to administer tube feeding as ordered by the Medical Doctor (MD). A review of Resident 33's physician order dated 7/8/2024, indicated the resident was to receive enteral formula (tube feeding) Novasource 2.0 at 35 ml/hr. for 20 hours every shift for dysphagia. During an observation on 7/23/2024 at 8:59 AM, Resident 1 was observed in their room. Resident 1 was observed with TF Novasource 2.0 running at 35 ml/hr. The TF was observed dated and labeled to have started at 7/23/2024 at 6 AM.	F 657		

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2.A review of Resident 83's Admission Record indicated the resident was initially admitted to the facility on 5/28/2024 and re-admitted on 7/9/2024 with diagnoses that included an elevated white blood cell count (an increase in cells in the blood that fight infections), adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability), and urinary tract infection (UTI, an illness in any part of the urinary tract, the system of organs that makes urine).

A review of Resident 83's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 6/4/2024, indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated the resident required supervision or touching assistance for eating and oral hygiene. The MDS further indicated the resident required substantial/maximal assistance for showering/bathing self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene.

A review of Resident 83's care plan revised 7/9/2024, indicated the resident required Intravenous (IV, a soft, flexible tube placed inside a vein, usually in the hand or arm. A medical technique that administers medication, fluids, and/or nutrients directly into a person's vein) therapy. The care plan indicated Resident 83 was receiving Meropenem (an antibiotic used to treat bacterial infections) 1 gram every 8 hours until 7/12/2024 and Vancomycin (an antibiotic used to treat bacterial infections) 1 gram every 12 hours for two weeks for pneumonia (an infection that inflames the air sacs in one or both lungs).

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A review of Resident 83's physician order dated 7/9/2024, indicated the resident was to receive Meropenem 1 gram intravenously every 8 hours for pneumonia until 7/12/2024.

A review of Resident 83's Medication Administration Record dated 7/1/2024 - 7/12/2024, indicated the resident completed receiving Meropenem on 7/12/2024.

A review of Resident 83's physician order dated 7/20/2024 indicated the resident was to receive Vancomycin 750 milligrams (mg) intravenously two times a day for pneumonia until 7/23/2024.

During an observation on 7/23/2024 at 10:50 AM, Resident 83 was observed in their room with and IV to their right hand. The IV dressing was observed clean, dry, and intact and dated 7/21/2024. The IV had tubing connected to a small medication bag of Vancomycin 750 mg. Resident 83 stated they received their Vancomycin antibiotic that morning.

During a concurrent interview and record review on 7/25/2024 at 11:45 AM, Resident 33's TF care plan and Resident 83's antibiotic care plans were reviewed with the Director of Nursing (DON). The DON stated Resident 33's tube feeding care plan and Resident 83's antibiotic care plan was not revised to reflect their current physician orders. The DON stated Resident 33 was receiving their TF at 35 ml/hr. not 40 ml/hr. The DON stated Resident 83 was no longer receiving Meropenem and was receiving Vancomycin 750 mg not 1 gram. The DON stated care plans are updated with a change of condition, upon admission, quarterly, or as needed. The DON stated care

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F 657	Continued From page 12 plans are revised as appropriate. The DON stated resident care plans should reflect current physician's orders and should be updated when a new physician order is received. The DON stated resident needs could potentially not be met if the care plan is not revised to reflect current physician orders. A review of the facility's policy and procedure titled "Care Plans, Comprehensive Person-Centered" revised 3/2022, indicated "Assessments of residents are ongoing and care plans are revised as information of the residents and the residents' condition change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conduction with the required MDS assessment".	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		

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HOLLYWOOD PREMIER HEALTHCARE CENTER	5401 FOUNTAIN AVE. LOS ANGELES, CA 90029

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F 686	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide services that promote the prevention of pressure ulcer injury (injury to the skin caused by pressure) for one of two sampled residents (Resident 190) as evidenced by failing to make sure the low air loss mattress (LALM-mattress designed to treat and prevent pressure ulcers) setting was correct. This deficient practice had the potential for worsening of pressure ulcer and harm to Resident 190. Findings: A review of Resident 190's Admission Record indicated the facility admitted the resident on 7/10/2024, with diagnoses including stage three (full thickness skin loss) pressure ulcer (injury to the skin caused by pressure) of unspecified region of back, and unstageable pressure ulcer (a type of pressure injury that occurs due to prolonged pressure on a specific area of the skin, resulting in the lack of blood flow and oxygen to the tissue) of right ankle and right heel. A review of Resident 190's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 7/17/2024, indicated the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 190 was at risk for developing pressure ulcers, had one stage three pressure ulcer that was present upon admission, was receiving pressure ulcer care, had pressure	F 686		

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F 686	Continued From page 14 reducing device for bed, and was receiving nutrition or hydration interventions to manage skin problems. A review of Resident 190's physician order dated 7/11/2024, indicated to apply a LALM for wound management according to resident`s weight and comfort. The order further indicated to check for placement and functioning of the LALM during every shift.  A review of Resident 190`s Care Plan for alteration (change) in skin by manifested by mid-spine (middle section of back) stage three pressure injury indicated that the resident is at risk for wound worsening, infection, pain, discomfort, and complications. The care plan interventions were to apply LALM for wound management according to resident`s weight and comfort. Check for placement and functioning of the LALM every shift. Monitor pain pre, during, and post assessment for wound care. Handle effected areas gently and keep the area clean and dry. Monitor for sign and symptoms of infection. During a concurrent observation, and interview on 7/22/2024 at 9:39 AM, with Treatment Nurse 2 (TN 2) inside Resident 190`s room, Resident 190 was observed laying on his bed with a LALM . TN 2 stated " the purpose of LALM is to prevent extra weight on the wound and the settings of the LALM are determined by the resident's weight ". TN 2 stated Resident 190 `s LALM set up is on 200. TN 2 further stated " Resident 190`s weight is 140 lbs., however the LALM was set on 200 lbs. The LALM setting is required to be consistent with the resident`s weight or comfort". TN 2 stated the potential outcome of incorrect LALM	F 686		

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set up is delayed wound healing and worsening of the wound.

A review of Resident 190's Weight Summary Record dated 7/15/2024, indicated that Resident 190 weighed 145 pounds (lbs.- a unit of weight).

During an interview on 7/25/2024 at 2:00 PM, with the facility`s Director of Nursing (DON), the DON stated " licensed staff are required to check and monitor residents` LALM placement, functioning and setting. The LALM settings are determined by the resident's weight and the incorrect settings on the LALM is a deficient practice". The DON stated the potential outcome is worsening of the resident`s pressure ulcer.

A review of the facility`s policy and procedure titled " Prevention of Pressure Ulcers/Injuries," reviewed 1/31/2024, indicated to teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Select appropriate support surfaces based on resident`s mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors.

A review of the facility`s undated policy and procedure titled " Support Surface Guidelines-Skin and Wound Management," indicated any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed. Refer to bed selection algorithm for support surface selection. Review the resident` care plan to assess for any special needs of the resident. Assemble the equipment and supplies as needed.

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F 686	Continued From page 16 A review of "Med-Aire Melody Alternating Pressure Low Air Loss mattress Replacement System Operator`s Manual," indicated determine the patient`s weight and set the control knob to that weight setting on the control unit.	F 686		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident	F 726		

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assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to maintain a yearly staff competency and mandated reporting elder and dependent adult abuse training for two of five sampled staff members.

This deficient practice had the potential for residents to not receive the appropriate level of care needed affecting quality of care and potentially leading to resident harm.

Findings:

During a review of Certified Nursing Assistant 3 `s (CNA 3) employee file on 7/25/2024, the employee file indicated missing annual employee competency skills check and mandated elder and dependent adults abuse reporting training records for the years from 2018 to 2022.

During a review of CNA 4's employee file on 7/25/2024, the employee file indicated missing annual employee competency skills check and mandated elder and dependent adults abuse reporting training records for the year 2022.

During a concurrent interview and record review on 7/25/2024 at 2 PM with Director of Staff Development (DSD), five sampled employees (CNA3, CNA 4, Licensed Vocational Nurse 2, Treatment Nurse 2, and Registered Nurse 1) files were reviewed. Two of the five reviewed employee files were missing yearly competency and skills check in between hire year and 2023. The DSD stated previous staff members handling staff trainings might have trimmed the employee

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F 726	Continued From page 18 files and stored it somewhere else. DSD was unable to locate the missing files. DSD stated that she assumed the DSD role a year ago and since then has engaged in training staff with the required competencies and updating employee files. DSD stated she is currently working on Quality Assurance Performance Improvement action plans (QAPI) to train all staff according to the standard practice and update employee files. During a review of QAPI dated 8/1/2023, the QAPI project indicated, DSD reviewed staff personal records policy and procedures, improvement in data retentions, creating new filing system and further evaluations. During an interview on 7/25/2024 at 2:30 PM with CNA 7, CNA 7 stated they had been working for the facility for over four years. CNA 7 was able to verbalize basic nursing skills tasks on intervention, resident positioning, activities of daily living, and abuse reporting mandates. CNA 7 was not able to recall if completed a yearly competency and skills check every year prior 2022. During an in interview on 7/25/24 at 2:35 PM with Director of Nursing (DON), the DON stated, the DSD took initiatives proactively from the start of her role as DSD and is working on QAPI projects to improve yearly staff competency trainings and retain employee records. DON stated consistent competency skills and mandatory abuse reporting trainings are the standard practices of the facility to ensure the quality of care of residents. During a review of the facility's undated policy and procedure titled "Personal Records," indicated "Personal records contain, as each may apply,	F 726		

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F 726	Continued From page 19 the following data: ... d. Orientation and training program records; e. Performance evaluations; ...Personal records shall be retained for a period of not less than five (5) years unless otherwise required by federal or state laws." During a review of the facility's policy and procedure titled "In-Service Training, All Staff," dated 2001, it indicated, "The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training."	F 726		
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify, address, and/or obtain necessary services for the behavioral health care needs for one of three sampled residents (Resident 9) . This deficient practice had the potential to lead to the inadequate care of Resident 9.	F 740		

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Findings:

A review of Resident 9's Admission Record (Face Sheet) indicated the facility admitted the resident on 3/28/2024, with diagnoses including schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), and heart failure (a condition that develops when your heart does not pump enough blood for your body's needs).

A review of Resident 9's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 7/3/2024, indicated the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 9 had diagnoses of schizophrenia, did not exhibit (display) rejection of care (behavior that interfere with caregiver-initiated efforts to assist an individual care recipient) and did not have hallucinations (a sight, sound, smell, taste, or touch that a person believes to be real but is not real) and delusions (a false belief or judgment about external reality). The MDS further indicated that Resident 9 was not taking antipsychotic medications (the main class of drugs used to treat people with schizophrenia).

A review of Resident 9`s physician History and Physical (H&P) dated 4/4/2024, indicated that Resident 9 did not have the capacity to understand and make decisions.

A review of Resident 9`s physician order dated 3/28/2024, indicated to administer Risperidone (a

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F 740	Continued From page 21 medication that is used to treat certain mental disorders such as schizophrenia) oral tablet one Milligram (mg - a unit of measurement) by mouth at bedtime for schizophrenia. A review of Resident 9`s physician orders dated 3/29/2024, and 6/4/2024, indicated to provide psychology (the study of the mind and behavior) consultation for the resident.  A review of Resident 9`s Medication Administration Record (MAR) for the month of March 2024, indicated that the order for Risperidone oral tablet one MG by mouth at bedtime for schizophrenia was discontinued on 3/29/2024 at 1:09 PM. A further review of Resident 9`s MARs indicated that Resident 9 did not receive Risperidone since her admission to the facility.  A review of Resident 9`s Care Plan initiated on 3/29/2024 , indicated that the resident had potential for alteration (a change) in behavior related to diagnosis of schizophrenia. The care plan goal was to minimize the risk of having any alteration in behavior for three months. The care plan interventions were to alter resident`s environment, provide activities to take resident for a walk if resident is upset. Encourage the resident to participate in activities daily. Provide psychiatric and psychology consultations as indicated and to monitor for any unusual behavior daily and report to the physician promptly (immediately). During a concurrent interview and record review on 7/23/2024 at 2:10 PM, with the facility`s Director of Nursing (DON), Resident 9`s physician orders were reviewed. The DON stated Resident 9 has a history of schizophrenia however, she is not taking any anti-psychotic	F 740		

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F 740	Continued From page 22 medications. The DON stated " When Resident 9 was admitted to the facility, I noticed that she was on Risperidone one MG at bedtime based on the hospital discharge medication list. I contacted the Administrator of the board and care (houses in residential neighborhoods that are equipped and staffed to help people with their daily routines) Resident 9 used to live and she informed me that Resident 9 had been taking this medication for a long time. However, she was not able to specify Resident 9`s behavior related to this medication and her diagnosis of schizophrenia. We did not resume the medication because Resident 9 did not display any behavioral issues during her stay in the facility". The DON further stated she did not consult Resident 9`s physician or any psychiatrist before discontinuing this medication. The DON stated the potential outcome is lack of care and follow up for necessary services. During a concurrent interview and record review on 7/24/2024 at 9:15 AM, Resident 9`s physician orders and care plans were reviewed. The DON stated Resident 9`s physician had ordered a psychology consultation on 3/29/2024 and 6/4/2024. However, the psychology evaluation was not done yet. The DON stated, " It was missed". The DON stated the potential outcome of not performing a psychology evaluation for a resident with schizophrenia is the inability to determine the necessary behavioral health services that resident is required to receive in the facility. The DON stated Resident 9`s care plan for schizophrenia was initiated on 3/28/2024, however, this care plan was not revised quarterly. The DON stated licensed nurses are required to review and revise residents` care plans at least quarterly, or when there is a change of condition. The DON stated the potential outcome of not	F 740		

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reviewing and revising resident`s care plan is the inability to evaluate the effectiveness of person-centered care plan interventions and inability to evaluate to see if desired outcome is met.

A review of the facility policy and procedure titled " Behavioral Assessment, Intervention and Monitoring," revised March 2019, indicated that the facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychological well-being in accordance with the comprehensive assessment and plan of care. Behavioral health services will be provided by qualified staff who have the competencies and skills necessary to provide appropriate services to the residents. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly.

A review of the facility policy and procedure titled " Psychotropic Medication Use," revised July 2022, indicated consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident`s sign and symptoms in order to identify underlying causes. Situations which may prompt an evaluation or re-evaluation of the resident include admission or re-admission. When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts as evaluation of the resident.

A review of the facility policy and procedure titled "Care Plans, Comprehensive Person-Centered,"

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F 740	Continued From page 24 revised March 2022, indicated the comprehensive, person-centered care plan includes measurable objectives and timeframes. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents` condition change. The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident`s condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly, in conjunctions with the required quarterly MDS assessment.	F 740		
F 755 SS=D	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. §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.	F 755		

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§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 observation, interview, and record review, the facility failed to clarify the strength and dose on a physician order for docusate sodium (a medication used to relieve difficulty passing stool and to treat constipation [a term used to describe difficulty passing stool]) liquid, for one of six sampled residents (Resident 1.)

This failure had the potential to result in Resident 1 receiving inadequate or excessive dosage of docusate sodium and increased risk for adverse consequences such as constipation or diarrhea due to not receiving medication per physician orders.

Findings:

During a review of Resident 1's Admission Record (a document containing demographic and diagnostic information), dated 07/23/2024, the admission record indicated, the facility admitted Resident 1 on 12/30/2013, and readmitted on 06/24/2017, with diagnoses including gastro-esophageal reflux disease ([GERD] - a medical term for a condition when stomach acid flows back into esophagus [the tube connecting mouth and stomach] without esophagitis [inflammation of esophagus]), seizures (a medical

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term used to describe sudden, uncontrolled burst of electrical activity in the brain), encephalopathy (a medical term used to describe brain disease with altered brain function), and dementia (a medical term used to describe loss of memory, cognition and judgement).

During a review of Resident 1's Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 07/08/2024, the MDS indicated resident was rarely or never understood. Resident 1's MDS indicated resident required full assistance from facility staff for activities of daily living (tasks of everyday life that include eating, personal hygiene, dressing, showering and toileting hygiene).

During an observation on 07/23/2024 at 9:02 AM, during medication pass, Licensed Vocational Nurse 1 (LVN) 1 prepared six medications for Resident 1, that included 25 mL of docusate sodium from a bottle that indicated Docusate Sodium liquid 50 milligrams (mg - a unit of measure for mass) per 5 milliliters (mL - a unit of measure for volume). LVN 1 poured out 25 mL dose in medicine cup to be administered to Resident 1 along with other medications.

During a review of Resident 1's Order Details, (a document containing ordered medication dose, time, quantity, frequency, and other medication details), dated 07/23/2024, the order indicated: "Docusate Sodium Oral Liquid, give 25 mL by mouth one time a day for Constipation Hold for loose stool. Order date 01/21/2024."

During a review of Resident 1's Medication Administration Record (MAR - a written record of all medications given to a resident) for May 2024,

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June 2024, and July 2024, dated 05/01/2024 to 05/31/2024, 06/01/2024 to 06/30/2024 and 07/01/2024 to 07/31/2024, the MAR indicated that the physician order was listed without a medication strength, concentration, and dose, indicated as follows:
"Docusate Sodium Oral Liquid (Docusate Sodium) give 25 ml by mouth one time a day for Constipation Hold for loose stool, order date: 01/21/2024 1526, D/C (discontinued) date 07/23/2024 1249."

During an interview on 07/23/2024 at 11:53 AM with LVN 1, LVN 1 stated docusate sodium liquid only had instructions for volume of 25 mL to be given but no dose or concentration of the liquid listed on the physician order. LVN 1 stated it was important to clarify the strength and dose on the physician order. LVN 1 stated if docusate sodium was not given in correct dose, it could potentially be an excessive dose causing loose stool, diarrhea, dehydration, and even hospitalization. LVN 1 stated if docusate sodium was not given in adequate dose, it would not relieve Resident 1's constipation causing gastrointestinal issues and health complications.

During an interview on 07/23/2024 at 4:39 PM, with the Director of Nursing (DON), the DON stated it was important to clarify the physician order for docusate sodium liquid to indicate dose and strength. The DON stated there would be a risk for resident to be not treated for constipation or suffer with episodes of diarrhea if he did not receive correct dose of docusate sodium liquid, which could increase the risk for hospitalization.

During a review of the facility's policy and procedure (P&P) titled, "Medication and

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F 755	Continued From page 28 Treatment Orders," dated 07/2016, the P&P indicated, "Orders for medications must include: a. name and strength of the drug; b. number of doses .... duration of therapy; c. dosage and frequency of administration; d. route ... ... f. any interim follow-up requirements .... monitoring, etc.)." During a review of the facility's P&P titled, "Administering Medications," dated 04/2019, the P&P indicated, "If a dosage is believed to be inappropriate or excessive for a resident, or ... ...will contact the prescriber, the resident's attending physician or ... ...to discuss the concerns. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered; b. the dosage .... g. the signature and title of the person administering the drug."	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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.	F 761		

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§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:

1. Ensure secure storage of controlled medications (a term used to describe prescription medications with high abuse potential) and non-controlled medications for one of six sampled residents (Resident 77) during medication administration.

2. Ensure proper labeling of insulin (a medication used to treat high blood sugar), per facility's policies and procedures (P&P) titled, "Medication Labeling and Storage" and manufacturer's requirements, affecting one resident (Resident 66) in one of two inspected medication carts (Middle Medication Cart).

These failures had the potential to result in medication errors, misuse, drug loss, diversion, and accidental exposure to controlled substances, and increased the risk for Resident 66 to receive insulin that had become ineffective or toxic due to improper labeling possibly leading to health complications and hospitalization.

Findings:

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F 761	Continued From page 30 1. During a review of Resident 77's Admission Record (a document containing demographic and diagnostic information), dated 07/24/2024, the admission record indicated, Resident 77 was originally admitted to the facility on 03/29/2024 and then re-admitted on 06/19/2024 with diagnoses including, but not limited to, peritoneal abscess (a medical term used to describe infection of the tissues lining abdominal wall, pelvic cavity and organs in the abdomen), gastro-esophageal reflux disease ([GERD] - a medical term for a condition when stomach acid flows back into esophagus [the tube connecting mouth and stomach] without esophagitis [inflammation of esophagus]), essential hypertension (a medical term used to describe high blood pressure), acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity (a medical condition to describe blood clot formation in deep veins in the legs), and seizures (a medical term used to describe sudden, uncontrolled burst of electrical activity in the brain). During a review of Resident 77's History and Physical, dated 06/21/2024, the document indicated resident "has the capacity to understand and make decisions." During a review of Resident 77's Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 05/03/2024, the MDS indicated Resident 77 had intact cognition (mental action or process of acquiring knowledge and understanding through thought and the senses). The MDS indicated Resident 77 required setup or clean-up assistance for eating and required full assistance from the facility staff for other activities of daily living (tasks of	F 761		

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everyday life that include oral hygiene, dressing, bathing, toileting, and personal hygiene).

During a review of Resident 77's Order Summary Report (a list of all currently active medical orders), dated 07/24/2024, the order summary report indicated the following list of medications:

"Acetaminophen (a medication used to treat fever and pain) oral tablet, give 500 milligrams (mg - a unit of measurement for mass) by mouth every 8 hours as needed for mild pain, order date: 06/28/2024, start date: 06/28/2024"
"Apixaban (a medication used to prevent and reduce the risk of blood clot), oral tablet 2.5 mg, give 1 tablet by mouth two times a day for deep venous thrombosis ([DVT] - a medical term to describe blood clot formation in deep veins in the body in the legs) prevention, order date: 06/28/2024, start date: 06/29/2024"
"Arginaid oral packet (nutritional supplement), give 1 packet by mouth two times a day for wound supplement, mix 1 packet with 8 ounces ([oz] - a unit of measurement for volume) of water, order date: 07/02/2024, start date: 07/02/2024"
"Ascorbic Acid (a dietary supplement to treat vitamin C deficiency) oral tablet 500 mg, give 500 mg by mouth one time a day for supplement, order date: 06/28/2024, start date: 06/29/2024"
"Cholecalciferol (a dietary supplement to treat vitamin D deficiency) oral tablet 25 microgram (mcg - a unit of measurement for mass), give 25 mcg by mouth one time a day for supplement, order date: 06/28/2024, start date: 06/29/2024"
"Famotidine oral tablet 40 mg, give 1 tablet by mouth in the evening for GERD, start date: 06/28/2024, start date: 06/29/2024"
"Keppra ([Generic name - Levetiracetam] a

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F 761	Continued From page 32 medication used to treat seizures) oral solution 100 mg / milliliters (mL - a unit of measurement for volume), give 10 ml by mouth two times a day for seizure, order date: 06/29/2024, start date: 06/29/2024" "Lacosamide (a medication used to treat seizures) oral tablet 200 mg, give 1 tablet by mouth two times a day for seizure, order date: 06/28/2024, start date: 06/29/2024" "Loperamide (a medication used to treat diarrhea) hydrochloride (HCl) 2 mg, give 1 tablet by mouth every 6 hours as needed for diarrhea, order date: 06/28/2024, start date: 06/28/2024" "Magnesium Chloride (a dietary supplement used to treat magnesium deficiency) oral tablet 64 mg, give 2 tablets by mouth four times a day for supplement for 14 days, order date: 07/21/2024, start date: 07/21/2024, end date: 08/04/2024" "Magnesium Chloride oral tablet 64 mg, give 2 tablets by mouth two times a day for supplement, start 08/04/2024, order date: 07/21/2024, start date: 08/04/2024" "Mobic ([Generic name - Meloxicam] a medication used to treat inflammation and pain) 15 mg (meloxicam), give 15 mg by mouth every 24 hours as needed for moderate pain, order date: 06/28/2024, start date: 06/28/2024" "Multi Vitamin (a dietary supplement to prevent and treat vitamin deficiency) oral tablet, give 1 tablet by mouth one time a day for supplement, order date: 06/28/2024, start date: 06/29/2024" "Pantoprazole (a medication used to treat acid reflux) sodium oral tablet delayed release 40 mg, give 1 tablet by mouth one time a day for GERD, order date: 06/28/2024, start date: 06/29/2024" "Potassium Chloride (a medication used to treat low levels of potassium) extended release (ER) oral tablet 20 milliequivalent (mEq - a unit of measurement for mass), give 1 tablet by mouth	F 761		

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one time a day for supplement, start 07/24/2024, order date: 07/21/2024, start date: 07/24/2024"
"Zinc (a dietary supplement to treat zinc deficiency) oral tablet, give 50 mg by mouth one time a day for supplement, order date: 06/28/2024, start date: 06/29/2024"
"Zofran ([Generic name - ondansetron] a medication used to treat nausea and vomiting), give 1 tablet by mouth every 6 hours as needed for nausea and or vomiting, order date: 06/28/2024, start date: 06/28/2024"

During an observation on 07/23/2024 at 9:42 AM outside of Resident 77's room, the Licensed Vocational Nurse (LVN) 1 prepared ten medications to administer to Resident 77 during medication pass. LVN 1 prepared the following medications in separate medicine cups:

Lacosamide 200 mg, 1 tablet
Arginaid, 1 packet dissolved in 240 mL water
Eliquis (apixaban) 2.5 mg, 1 tablet
Vitamin C 500 mg, 1 tablet
Vitamin D 25 mcg, 1 tablet
Levetiracetam 100 mg/mL, 10 mL
Magnesium DR 64 mg, 2 tablets
Multivitamin, 1 tablet
Potassium Chloride 20 mEq ER, 1 tablet
Zinc 50 mg, 1 tablet

During a concurrent observation and interview at 07/23/2024 at 9:50 AM with LVN 1, Resident 77 was wheeled out of her room by the facility staff to take shower. LVN 1 stated she would have to return to Resident 77's room after she got back from shower to administer medications.

During an observation on 07/23/2024 at 10:13 AM, Resident 77's ten medications listed above

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were left in a medication tray unattended on Station 2 Medication Cart countertop. LVN 1 stepped away for approximately five minutes from Station 2 Medication Cart to attend another resident.

During an observation on 07/23/2024 at 10:38 AM in Resident 77's room, LVN 1 administered medications listed above.

During an interview on 07/23/2024 at 11:53 AM with LVN 1, LVN 1 stated she would usually stay with the medication cart to keep medications safe and secure and to prevent accidental exposure to other residents. LVN 1 stated she did not have space inside medication cart to store the prepared medications securely. LVN 1 stated medications should not have been left unattended because of increased risk of diversion and accidental exposure. LVN 1 stated lacosamide was a controlled medication with a potential for dependence and abuse, and it was important for it to be properly secured along with other medications, to prevent unintended use by facility staff or residents potentially leading to adverse reactions and hospitalization.

During a review of the facility's policy and procedure (P&P) titled, "Medication Labeling and Storage," dated 02/2023, the P&P indicated, "Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others."

2. During an observation and inspection on

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07/23/2024 at 3:59 PM of Middle Medication Cart with LVN 4, the following medication for Resident 66 was found stored in the medication cart labeled with two different dates, which was not in accordance with manufacturer's requirements and facility's policy and procedure.
Novolin R (a medication in the category of insulin used to treat high blood glucose level) 100 units (a unit of measurement for insulin) / milliliters (mL - a unit of measure for volume) insulin vial for Resident 66, had a hand-written date of 07/12/2024 on outside pharmacy container, and a hand-written date of 06/26/2024 on a green "date opened label" on the insulin vial inside the container.
According to the manufacturer's product labeling, unopened / not in-use vial and opened / in-use vial if stored at room temperature (up to 77°F [25°C]) must be used within 42 days.

During an interview on 07/23/2024 at 4:08 PM with LVN 4, LVN 4 stated the insulin vial should only have one opened date to accurately determine expiration date and stability, and to ensure removal from the medication cart if expired. LVN 4 stated she would call pharmacy to replace the insulin vial because it had two different opened dates making it unclear to determine when the medication was removed from the refrigerator or when it was opened. LVN 4 stated expired insulin could cause hyperglycemia (a term used to describe high blood glucose level) or hypoglycemia (a term used to describe low blood glucose level) for the resident.

During an interview on 07/25/2024 at 12:11 PM with the Director of Nursing (DON), DON stated the licensed nurse would label the insulin vial with

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F 761	Continued From page 36 an opened date when the nurse opened the vial to be used for a resident. DON stated the licensed nurse should discard the insulin vial after 28 days if removed from the refrigerator. DON stated the licensed nurse should place the opened date label on the immediate container, that is, on the insulin vial, not on the outside pharmacy container. DON stated the safety and efficacy of insulin could be affected if the insulin stored at room temperature with an unclear date was administered, which could potentially cause the resident to become hypoglycemic or hyperglycemic resulting in hospitalization. During a review of the facility's P&P titled, "Medication Labeling and Storage," dated 02/2023, the P&P indicated, "Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. The medication label includes, at a minimum: a. medication name .... d. expiration date .... g. appropriate instructions and precautions."	F 761		
F 802 SS=D	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff.	F 802		

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The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.

§483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii).
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure the Dietary staff had the appropriate competencies and skills when:

1. Dietary Aide (DA 1) failed to verbalize and follow the manufacturer's guidelines of QT-40 test paper (a type of test strip) when checking the Quaternary Ammonium Compounds (Quats, a group of chemicals used to disinfect surfaces and equipment) sanitizer concentration.

This failure had a potential to result in potential cross-contamination (a transfer of bacteria from one object to another), unsanitized food preparation areas and bacterial growth to food that could lead to food borne illness (an illness caused by contaminated food and beverages) for the 88 residents who received food from the kitchen.

Findings:

During a concurrent observation and interview on 7/23/2024 at 9:05 AM, with DA 1, observed DA 1 demonstrate red bucket sanitizing solution testing. Observed DA 1 fill red bucket with a sanitizer solution labeled "Keystone Multi-Quat Sanitizer" by the three-compartment sink. DA 1

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dropped sanitizer test strip in the red bucket with sanitizer and removed test strip right away. DA 1 compared the color of the testing strip on the color reference chart. According to the color reference chart on the QT-40 test paper, the testing strip showed a reading of 400 parts per minute (PPM). When asked what level the strip should read, DA 1 stated he was unsure. DA 1 stated that it is important to perform the quat test correctly because there is a potential for the dishware to be improperly sanitized.

A review of the Quat sanitizer test strips manufacturer guidelines titled "QT-40 Lot 221422 Exp 8/1/2024" it indicated that testing strips should be left for a total of 10 seconds in the solution before removing. Once testing strip removed it should be compared to the color reference chart on the.

A review of the facility's red bucket log titled "Temperature/Sanitizer Record" dated July 2024, it indicated that the sanitizer PPM level should be at 200 PPM.

During an interview on 7/23/2024 at 10:56 AM with the Registered Dietician (RD), RD has been serving as the temporary Dietary Supervisor (DS) for a week and currently oversees the Dietary Department. RD stated that annual competencies and in-services for the kitchen staff are usually completed by the DS. RD stated that all Dietary Staff should have completed all their annual competencies but stated that she was unsure since she had just started this position.

A review of DA 1's employee records indicated that DA 1 began employment on 10/17/2016 with the job title Dietary Aide, under the Dietary

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Department. A review of the facility's Dietary Aide Competency title "Cook/Kitchen Competency Assessment" dated 12/11/2023, it indicated that DA 1 received an annual competency evaluation on 12/11/2023 for Dietary Aide and that all skills were completed and checked off by the DS on 12/11/2023.

During an interview with the Director of Staff Development (DSD) and the Director of Nursing (DON), DSD stated that both the DSD and DS oversee the competency and skills evaluation for the Dietary Department. DSD stated that the DS should have educated and evaluated those with the job title of Dietary Aides on how to test the sanitation solutions. DON stated that if sanitation solutions are not tested correctly, it can lead to improper sanitation of kitchen equipment such as dishes, utensils, or pots which can potentially lead to food born illnesses.

A review of the facility's document dated 1/2012 and titled "Dietary Aide", it indicated that the general role of the Dietary Aide is to follow all directions regarding sanitation.

A review of the facility's policy and procedure titled "Infection Prevention and Control" revised December 2023, it indicated all personnel are trained on infection prevention and control policies and procedures upon hire and periodically thereafter, including how to use appropriate procedures and equipment related to infection control. It also indicated that personnel training is consistent with job responsibilities and competency demonstrations may be required for certain policies and procedures
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	056489	A. BUILDING ____ B. WING ____	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLYWOOD PREMIER HEALTHCARE CENTER	5401 FOUNTAIN AVE. LOS ANGELES, CA 90029

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

§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.
(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 observe proper food storage and handling when:

1. A package of cookies was found left opened and undated on a shelf in the kitchen's pantry.

2. The Cook (Cook 1) went to rinse a towel in the sink and the cook did not wash his hands prior to serving prepared food during the facility's lunch tray line.

These failures had the potential to result in residents acquiring food borne illnesses.

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Findings:

During a concurrent observation and interview during the initial kitchen tour on 7/22/2024 at 7:50 AM, a package of cookies was found opened and undated in the back of a shelf in the kitchen's pantry. Showed Cook 1 the opened package of cookies and per Cook 1, all packaged foods that are opened should be stored in a new container and dated with the open date immediately after opening. Cook 1 then proceeded to discard the opened package of cookies. Cook 1 stated that it was important to properly store foods because the food is at risk of getting spoiled, which can potentially cause residents to get sick if they are to eat it.

During an interview with the Registered Dietitian (RD) on 7/23/2024 at 10:56 AM, RD stated that she is responsible for overseeing the kitchen staff. The RD stated that all dry foods that are opened should be repackaged and dated with the open date to prevent the food from becoming spoiled. The RD stated that food that has been left opened is at risk with being contaminated by insects or rodents, which can lead to the residents acquiring a food borne illness if the food is consumed.

A review of the facility's policy and procedure titled "Food Receiving and Storage" revised November 2022, it indicated that foods shall be received and stored in a manner that complies with safe food handling practices. It further indicated that dry food and goods are handles and stored in a manner that maintains the integrity of the packaging until they are ready to use.

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F 812	Continued From page 42 During a concurrent observation and interview on 7/23/2024 at 12:00 PM in the kitchen, Cook 1 was observed serving food during the facilities lunch tray line. Cook 1 left the area where they were serving food and proceeded to the sink area to rinse off a towel. Cook 1 then continued to serve food without washing their hands. Cook 1 stated that he forgot to wash his hands before returning to serve food and that stated that he should have washed his hands because he could have contaminated the food. During a concurrent interview and record review on 7/24/2024 at 9:07 AM with the Director of Staff Development (DSD) and the Director of Nursing (DON), DSD stated that annual competency for kitchen staff was done on a yearly basis and that the focus was on infection control (such a temperature control and hand washing). DSD stated that it was important for the kitchen staff to routinely perform good hand washing practices as there was a potential risk for cross contamination to occur which could lead to residents acquiring a food borne illness. A review of the facility's job description dated 1/2012 and titled "Dietary-Cook", it indicated that the cook is responsible for assuring that strict sanitation standards are followed in accordance with the State and Federal regulation. A review of the facility's policy and procedure titled "Handwashing/Hand Hygiene," revised on October 2023, it indicated that all personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.	F 812		
F 880 SS=E	Infection Prevention & Control	F 880		

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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;
(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

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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 failed to implement infection prevention and control measures for six of 18 sampled residents (Resident 1, Resident 4, Resident 70, Resident 77 Resident 38 and Resident 85) when:

1. Restorative Nursing Aide 1 (RNA 1) did not use the appropriate cleaning agent to effectively clean and disinfect a cloth gait belt (safety device worn

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around the waist that can be used help safely transfer a person from one surface to another or while walking) after completing Restorative Nursing Aide (RNA, nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) walking exercises with Resident 38.

2. Resident 85's urinals were found hanging on the inside of a trashcan next to the resident's bed.

3. The medication cart countertop and medication trays were not disinfected in between resident room visits for Resident 1, 4, 70 and 77.

These failures had the potential to contaminate medications and cause spread of infection in the facility.

Findings:

1. A review of Resident 38's Admission Record indicated the facility admitted Resident 38 on 12/12/2023, with diagnoses including end stage renal disease (chronic kidney disease that causes gradual loss of kidney function) and congestive heart failure (weakness of the heart that leads to buildup of fluid in the lungs and other parts of the body).

During an observation and interview on 7/23/2024 at 3:09 PM, in the resident's room, Resident 38 was sitting at the edge of the bed. RNA 1 placed a cloth gait belt around Resident 38's waist, placed a front wheeled walker (mobility device with two wheels in the front used for support when standing or walking) in front of Resident 38's body, and assisted Resident 38 into a standing position. RNA 1 assisted Resident 38 to

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walk down the hallways holding onto the gait belt while Restorative Nursing Aide 2 (RNA 2) followed behind with a wheelchair. After completing walking exercises, Resident 38 sat in a wheelchair in the hallway. RNA 1 removed Resident 38's gait belt from around the waist, walked to the front desk of the facility to obtain disinfectant wipes, and wiped down the cloth gait belt with disinfectant wipes. RNA 1 stated the cloth gait belt was made of fabric and used disinfecting wipes called Super Sani-Cloth disposable wipes to disinfect the cloth gait belt after use with Resident 38. RNA 1 stated it was important to properly clean and disinfect cloth gait belts before and after resident use to prevent the spread of infection.

During an interview on 7/24/2024 at 2:20 PM, the Infection Preventionist Nurse (IPN) stated cloth gait belts were made of fabric, a porous (having small spaces or holes through which liquid or air may pass) material. The IPN reviewed the manufacturer instructions for the Super Sani-Cloth disposable wipes and confirmed the wipes were to be used on hard, non-porous surfaces only for disinfection. The IPN stated cloth gait belts should not be cleaned and disinfected with Super Sani-Cloth wipes after resident use because it was not the appropriate cleaning agent to use on porous material. The IPN stated the only way to properly clean and disinfect cloth gait belts was to launder them after each resident use. The IPN stated it was important to clean and disinfect shared equipment properly and according to manufacturer's recommendations to maximize infection control, ensure the cleaning was effective, and to prevent the spread of infection.

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During an interview on 7/24/2024 at 2:38 PM, the Director of Maintenance and Housekeeping (DM) stated the Super Sani-Cloth disposable wipes should be used to disinfect hard, non-porous surfaces only and were not appropriate cleaning agents for any equipment made of fabric. The DM stated it was important to clean and disinfect shared equipment properly and according to manufacturer's instructions to prevent the spread of infection.

During an interview on 7/25/2024 at 9:56 AM, the Director of Nursing (DON) stated shared resident equipment such as gait belts must be cleaned and disinfected before and after each resident use. The DON stated it was important shared resident equipment was cleaned and disinfected appropriately and according to manufacturer's guidelines to prevent the spread of infection.
2. A review of Resident 85's Admission Record indicated the facility admitted the resident on 7/5/2024 with diagnoses including lack of coordination, unsteadiness on feet, and fatty liver (a condition in which fat builds up in your liver).

A review of Resident 85's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 7/12/2024, indicated the resident was cognitively intact (has the ability to think, understand, and reason). The MDS indicated Resident 85 required partial/moderate assistance for eating, oral hygiene, and upper body dressing. The MDS indicated Resident 85 required substantial/maximal assistance for lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 85 was dependent on assistance for toileting hygiene, and showering/bathing self. The MD further indicated Resident 85 was frequently

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incontinent (unable to control) of urine and always incontinent of bowel.

During a concurrent observation and interview on 7/22/2024 at 8:55 AM, Resident 85 was observed in their room lying in bed. Next to the right side of Resident 85's bed, two urinals were observed hanging on the inside of a trash can. Resident 85 stated they put the urinals in the trash can because that was how they could reach them. Licensed Vocational Nurse (LVN) 6 verified Resident 85's urinals were hanging on the inside of the trashcan by the resident's bed and stated the urinals should not have been placed there. LVN 6 stated the urinals should have been placed on urinal holder. LVN 6 stated placing Resident 85's urinals in the trash can could lead to infection control issues.

During an interview on 7/25/2024 at 11:45 AM, the Director of Nursing (DON) stated urinals should not be placed in the trash can. The DON stated the facility had holders for the urinal so that the urinal can be placed within the resident's reach. The DON stated urinals in the trash can create issues with infection control.
3a. During a review of Resident 1's admission record (a document containing demographic and diagnostic information), dated 07/23/2024, the admission record indicated, Resident 1 was admitted to the facility on 12/30/2013 and readmitted on 06/24/2017 with diagnoses including, but not limited to, gastro-esophageal reflux disease ([GERD] - a medical term for a condition when stomach acid flows back into esophagus [the tube connecting mouth and stomach] without esophagitis [inflammation of esophagus]), seizures (a medical term used to describe sudden, uncontrolled burst of electrical

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activity in the brain), encephalopathy (a medical term used to describe brain disease with altered brain function), and dementia (a medical term used to describe loss of memory, cognition and judgement).

During an observation on 07/23/2024 at 9:02 AM during medication pass, Licensed Vocational Nurse (LVN) 1 prepared medications in separate medicine cups and placed them in a medication tray on bedside table in Resident 1's room. LVN 1 administered medications on 07/30/2024 at 9:21 AM. LVN 1 did not disinfect medication tray and the medication cart countertop after medication administration.

3b. During a review of Resident 4's admission record, dated 07/24/2024, the admission record indicated, Resident 4 was admitted to the facility on 01/29/2024 with diagnoses including but not limited to, paranoid schizophrenia (a mental health condition that disrupts areas of brain, affecting thinking abilities and differentiating between what is real and what is not real), essential hypertension (a medical term used to describe high blood pressure), generalized muscle weakness, and unspecified osteoarthritis (a medical term to describe chronic inflammation and pain of joints).

During an observation on 07/23/2024 at 9:28 AM during medication pass, LVN 1 prepared medications in separate medicine cups to administer to Resident 4 and placed them in medication tray which was then placed on bedside table in Resident 4's room. LVN 1 was not observed disinfecting medication tray that was brought from previous resident's room and the medication cart countertop in between visiting

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resident rooms.

3c. During a review of Resident 70's admission record, dated 07/24/2024, the admission record indicated, Resident 70 was admitted to the facility on 10/20/2023 with diagnoses including, but not limited to, encephalopathy, essential hypertension, and type 2 diabetes mellitus (a medical condition described by the inability to control blood sugar) without complications.

During an observation on 07/23/2024 at 9:41 AM, LVN 1 prepared medications in separate medicine cups to administer to Resident 70 and placed them in medication tray which was then placed on bedside table in Resident 70's room. LVN 1 was not observed disinfecting medication tray that was brought from previous resident room and the medication cart countertop in between visiting resident rooms with medication trays.

3d. During a review of Resident 77's admission record, dated 07/24/2024, the admission record indicated, Resident 77 was originally admitted to the facility on 03/29/2024 and then readmitted on 06/19/2024, with diagnoses including, but not limited to, peritoneal abscess (a medical term used to describe infection of the tissues lining abdominal wall, pelvic cavity and organs in the abdomen), gastro-esophageal reflux disease without esophagitis, essential hypertension, other seizures, and sepsis (a medical condition when chemicals are released in the bloodstream to fight an infection causing inflammation throughout the body).

During an observation on 07/23/2024 at 9:42 AM, LVN 1 prepared medications in separate medicine cups to administer to Resident 77 and

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placed them in medication tray which was then placed on the medication cart countertop. Resident 77 was taken for shower and LVN 1 stated she would have to return to administer medications.

During an observation on 07/23/2024 between 10:27 AM and 10:38 AM, LVN 1 administered medications to Resident 77. LVN 1 was not observed disinfecting medication tray and the medication cart countertop in between visiting resident rooms with medication trays.

During an interview on 07/23/2024 at 12:11 PM, LVN 1 stated she did not continue to disinfect trays in between each resident's medication administration. LVN 1 stated she disinfected trays at the start of medication pass and she washed hands and sanitized hands to prevent spread of infection in between residents. LVN 1 stated she would wash medication trays at the end of medication pass. LVN 1 stated this lack of disinfecting medication trays in between resident rooms and during medication pass would increase risk for spread of infection in the facility.

During an interview on 07/23/2024 at 4:39 PM, the Director of Nursing (DON), the DON stated facility should use hand sanitizer and disinfect equipment during medication administration. DON stated it is important to disinfect medication trays in between resident room visits during medication administration to prevent the spread of infection.

During a review of the facility's P&P titled, "Administering Medications," dated 04/2019, the P&P indicated, "staff follows established facility infection control procedures .... administration of

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medications, as applicable."

During a review of the facility's Policy and Procedure (P/P), revised 9/2022, titled, "Cleaning and Disinfection of Resident-Care Items and Equipment," indicated "resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard." The P/P further indicated reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions. "Reusable items are cleaned and disinfected or sterilized between residents. Non-critical items are those that come in contact with intact skin but not mucous membranes. Non-critical environmental surfaces include bed rails, bedside tables, etc. Intermediate and low-level disinfectants for non-critical items include ethyl or isopropyl alcohol, sodium hypochlorite, phenolic germicidal detergents, iodophor germicidal detergents and quaternary ammonium germicidal detergents (low-level disinfection only)."

A review of the facility's policy and procedure titled "Policies and Procedures - Infection Prevention and Control" revised 12/2023, indicated "The facility adopted infection prevention and control policies and procedures are intended to help maintain a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Infection prevention and control policies and procedures apply to all personnel, consultants, contractors, residents, visitors, and volunteers. The objectives of the infection

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(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 880	Continued From page 53 prevention and control policies and procedures are to monitor, prevent, detect, investigate, and control infections in the facility; maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public; and provide evidence - based guidelines for infection prevention and control based on current best practices. A review of the facility's policy and procedure titled "Bedpan/Urinal, Offering/Removing" reviewed 1/31/2024, indicated "After Assisting the Resident ...Clean the bedpan or urinal. Wipe dry with a clean paper towel. Discard paper towel into designated container. Store the bedpan or urinal per facility policy. Do not leave it in the bathroom or on the floor ...Clean wash basin and return to designated storage area".	F 880		
F 911 SS=B	Bedroom Number of Residents CFR(s): 483.90(e)(1)(i) §483.90 (e)(1) Bedrooms must §483.90(e)(1)(i) Accommodate no more than four residents. For facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, bedrooms must accommodate no more than two residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of 35 residents` rooms did not accommodate more than four residents. This deficient practice had the potential to result in inadequate space to provide safe nursing care	F 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056489	A. BUILDING ______ B. WING ______	07/25/2024

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F 911	Continued From page 54	F 911		

and privacy for the residents.

Findings:

On 7/22/2024 at 8:45 AM, during initial tour of the facility, it was observed that one resident room had five resident beds.

A review of the facility`s letter to the Department of Public Health, dated 7/22/2024, indicated that the facility is requesting a wavier to be granted on the condition that there is ample (enough) room to accommodate wheelchairs, and other medical equipment as well as space for mobility and movement of ambulatory residents. There is adequate space for nursing care, and the health and safety of the residents occupying this room are not in jeopardy. The room is in accordance with the safety of the residents and do not impede (delay or prevent) the ability of any residents in the room to allow his/her highest practicable wellbeing.

During an observation on 7/23/2024 at 1:33 PM, Observed two residents (Residents 34 and 54) inside the room with five beds. Both residents were not interview-able.

During an interview on 7/25/2024 at 2 PM, with Certified Nursing Assistant 5 (CNA 5) , CNA 5 stated she has been assigned to residents in the room with five resident beds . CNA 5 stated " there is enough space to move around and provide resident care in the room with five beds".

During an interview on 7/25/2024 at 2:28 PM with CNA 6, CNA 6 stated there are two residents inside the room with five beds. CNA6 stated she never had any concerns regarding residents not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056489	A. BUILDING ______ B. WING ______	07/25/2024

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F 911	Continued From page 55 having enough space in this room. During the survey from 7/22/2024-7/25/2024, it was observed that the nursing staff had full access to provide treatment, administer medications, and assist residents to perform their individual routine activities of daily living.	F 911		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain sanitary environment and prevent infestation of flies in and around a waste segregation and disposal area by leaving a trash bin open and overfilled with food leftovers and waste materials. This failure had the potential to affect residents in the facility, flies infecting and causing disease outbreaks. Findings: During an observation on 7/23/2024 at 2:34 PM, the facility waste segregation and disposal area was observed with two open trash bins filled with food leftovers, trash spilled over, and flies swarming in and around the open trash bins. During an interview on 7/23/2024 at 2:40 PM, with the facility Maintenance Supervisor (MS), MS was shown the open trash bins filled with leftover food items and waste materials. There were at least	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056489	A. BUILDING ______ B. WING ______	07/25/2024

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F 925	Continued From page 56	F 925		

ten or more flies swarming in and around the open trash bins. MS stated pest control is visiting the facility regularly. MS stated flies are potential risks for infection outbreak and having open and overfilled trash bins are not acceptable practice of the facility. MS to provide pest control visitation documents.

During an interview on 7/24/2024 at 1:40 PM with the Director of Nursing (DON), the DON stated facility maintenance handles the waste and trash segregation area. A third-party pest control company visits the facility in a regular basis. DON stated having any kind of pest in and around the facility is not the standard practice and potential risk factor for infection outbreaks.

During an interview on 7/24/2024 at 2:20 PM with the Infection preventionist Nurse (IPN), IPN stated pest control is a team effort, facility maintenance and environment team maintains trash bin area. IPN stated flies are potential risks for infection outbreaks in the facility. IPN stated it is against the facility infection prevention policy to have pests in the resident care areas.

During an interview on 7/25/2024 at 08:38 AM with facility Environment Aide (EA), the EA stated maintaining the trash bins areas are part of his responsibilities. EA stated having flies and other pests in or around the facility is a potential for infection outbreak.

During a review of ORKIN pest control company's invoice dated 7/19/2024, it indicated the following:
- Date of service 7/19/2024 complete interior and exterior inspection and treatment provided. Recommendation to clean and sanitize area of building perimeter for insect and rodent control.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056489	A. BUILDING ______ B. WING ______	07/25/2024

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F 925	Continued From page 57 Date of service 6/20/2024 complete interior and exterior inspection and treatment provided. Observation of uncovered trash on 5/3/2024, 4/5/2024, 3/15/2024, 3/1/2024, 2/16/2024. Recommendation to cover trash in the interior /building area. During further observation on 7/25/2024 at 4:02 PM, in the facility's conference room, during an exit conference with the facility staff, a dark greenish approximately ¼ cm long fly was observed flying in the conference room and exited to the resident care area. A review of facility`s policy and procedure titled " Pest Control," reviewed 1/31/2024, indicated our facility shall maintain an effective pest control program. This facility maintains an ongoing pest control program to ensure that the building is kept free of insects or the rodents. Garbage and trash are not permitted to accumulate and are removed from the facility daily. Pest control services are provided by ORKIN. Maintenance services assist when appropriate and necessary, in providing pest control services. A review of undated article by ORKIN pest control agency titled "A Guide to IPM (integrated pest management) In Long-Term Care Facilities." it indicated, "Flies are more than a nuisance; they also can spread germs rapidly. Covering distances quickly, they might feed on garbage one minute and a resident's food the next. Flies carry staphylococcus, E.Coli and salmonella, and can drop bacteria wherever they land. They produce rapidly and are hard to control once they gain entry."	F 925		

Hollywood Premier makes every effort to comply with the state and Federal regulations. Nothing in this plan of correction is an admission otherwise. Hollywood Premier submitted this plan of correction to comply with the State and Federal regulations and does not waive any objection obtained. This plan of correction is our credible allegation of compliance for the deficiency during our Annual Recertification Survey conducted and completed on 7/25/2024

F584

CORRECTION ACTION

On 7/23/2024, Residents were transferred to another room. Residents were agreeable and satisfied with the room change.

On 7/29/2024, the maintenance supervisor/third party started the repair of the floor surface damaged.

On 8/2/2024, the repair was finished.

OTHER RESIDENT AFFECTED IDENTIFICATION

On 7/23/24, the DON/Maintenance Sup/DSD conducted room rounds to ensure no other rooms had damaged floor surface. No other residents were affected by the same deficient practice.

MEASURES ANY SYSTEMIC CHANGES

On 8/13/2024, the maintenance supervisor provided in-services to Maintenace & housekeeping staff on facility's policy and procedure titled "Homelike Environment" with emphasis on providing residents with a safe, clean and comfortable environment.

On a daily basis, housekeepers clean the room daily and as needed to ensure they inspect the floor for any damaged floor surface and report it to the maintenance supervisor.

On a weekly basis, the Maintenance Supervisor will conduct floor checks of all the residents' rooms in the facility. X 3 months. Any damaged, cracked, or chipped floors will be repaired and replaced as needed. Any negative findings with be reported to the Administrator.

PERFORMANCE MONITORING

The Administrator/Director of Nursing (DON)/Maintenance Supervisor will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

COMPLETION DATE: 8/23/2024

F656

CORRECTION ACTION

On 7/10/2024, CarePlan was initiated as "antibiotic as ordered", without specifying the medication.

ATB therapy course was completed on 7/24/2024.

OTHER RESIDENT AFFECTED IDENTIFICATION

On 8/13/2024, the DON/HID/IP conducted an audit of new antibiotic medication orders from 8/5/2024-8/13/2024 to ensure that care plans were initiated or revised for these medications. No other resident were affected by the same deficient practice.

MEASURES AND SYSTEMIC CHANGES

On 5/30/2024 , 7/31/2024 and 8/13/2024 - DON conducted in-service with all licensed nurses and facility IDT on facility's policy and procedure on comprehensive care plan, Care Plan timing & Revision with emphasis on developing and implementing a comprehensive, person-centered care plan for each resident, as well as the process of initiating, updating/revising care plan.

Any changes to the resident's care will be updated by licensed nurses accordingly.

HID/Designee will audit all COC's daily to ensure a CarePlan has been developed and initiated for the resident.

During clinical meetings/standing meeting daily, the Clinical Team will review any residents with changes in conditions to ensure resident's care plan is initiated and revised as needed.

MDS nurses will review and update resident's care plans per OBRA MDS schedule and as needed.

The resident's care plan will be discussed and be re-evaluated by the interdisciplinary team with the resident/resident representative during care plan conference meeting at least quarterly and as needed based on the resident's condition and needs.

PERFORMANCE MONITORING

The Director of Nursing (DON)/Designee/HID will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

COMPLETION DATE: 8/23/2024

F657

CORRECTION ACTION

On 7/25/2024, The RN supervisor revised resident 33's care plan to ensure the care plan reflected current physician order.

OTHER RESIDENT AFFECTED IDENTIFICATION

On 8/13/2024, the DON/HID conducted an audit of all residents with feeding tube orders to ensure care plan reflected current tube feeding order. No other resident were affected by the same deficient practice.

MEASURES AND SYSTEMIC CHANGES

On 7/25/2024, 1:1 in-service conducted with licensed nurses regarding policy and procedure on comprehensive care plan, Care Plan timing & Revision, Individualize Care Plan.

On 5/30/2024 ,7/31/2024 and 8/13/2024 - DON conducted in-service with all licensed nurses and facility IDT on facility's policy and procedure on comprehensive care plan, Care Plan timing & Revision with emphasis on developing and implementing a comprehensive, person-centered care plan for each resident, as well as the process of initiating, updating/revising care plan.

Any changes to the resident's care will be updated by licensed nurses accordingly.

HID/Designee will audit all orders daily to ensure a CarePlan has been initiated and revised for the resident.

During Clinical meeting. The clinical team will check all new physicians order to ensure care plan has been initiated or revised for the resident.

PERFORMANCE MONITORING

The Director of Nursing (DON)/QA/MDS will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

COMPLETION DATE: 8/23/2024

F686

CORRECTION ACTION

On 7/22/2024, Treatment nurse ensured resident 190 LAL setting was corrected.

OTHER RESIDENT AFFECTED IDENTIFICATION

On 7/22/2024, Treatment nurses/DON conducted visual checked all resident on LAL mattress to ensure correct setting. No other residents were affected by the same deficient practice.

MEASURES ANF SYSTEMIC CHANGES

On 7/31/2024 and 8/13/2024, the DON conducted in-service with all licensed nurses, on facilities policy and procedure on following:

- Support Surface Guidelines (skin and Wound Management)
- Pressure Ulcer/Skin Breakdown (Skin and Wound Protocol)

On 7/31/2024, DSD conducted in –services with all CNA/Nurse Aid/RNA on P&P Pressure Ulcer/Skin Breakdown and Low Air Loss Mattress setting.

Licensed nurses will monitor the LAL setting q shift daily in recorded to eTAR.

The DON/QA/Designee/RN sup, randomly check LAL setting log daily x 3 months

PERFORMANCE MONITORING

The Director of Nursing (DON)/QA/Designee will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

COMPLETION DATE: 8/23/2024

F726

CORRECTION ACTION

Facility DSD identified lapse in recordkeeping of competency on October 2023.

October 2023- November 2023 DSD conducted competency of all nursing staff currently working at that time

DSD confirmed that CNA 3 had skills competency on 10/09/2023 and abuse training on 10/09/2023.

DSD confirmed that CNA 4 had skills competency on 10/09/2023and abuse training on 10/09/2023.

OTHER RESIDENT AFFECTED IDENTIFICATION

The competence of all nursing staff currently working is up to date.

MEASURES AND SYSTEMIC CHANGES

Upon hire, annually and as needed, DSD will ensure skills competency and abuse training are conducted

DSD/Admin will spot check employee files on a bi-weekly basis to ensure skills competency and abuse training are current for 3 months.

PERFORMANCE MONITORING

The Director of Staff Developer will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

COMPLETION DATE: 8/23/2024

F740

CORRECTION ACTION

On 7/24/2024, Behavioral Health care services were done for the resident by psychiatrist. On 7/24/2024 Psychiatrist conducted evaluation resident 9 . Per psychiatrist, no medication is recommended for this resident.

On 8/12/2024, Psych consulted with resident 9. Per Psych, the Pt has been stable with no acute exacerbations reported by nursing. Pt reports having clear thoughts, denies any anxiety or depression. Pt denies any Auditory and visual hallucinations. Pt today was in the activity room, with anticipation in grouts. "I had a good day". No changes or medication intervention warranted at this time. Pt able to comply with nursing services. Benefits outweigh the risks. Plan: Continue with POC

OTHER RESIDENT AFFECTED IDENTIFICATION

On 8/16/2024 the HID audit conducted on all residents with order for psych eval to ensure evaluations were carried out by psychiatrist and psychologist.

MEASURES AND SYSTEMIC CHANGES

On 7/31/2024 and 8/13/2024, The DON in-service provided to LN on residents' policy and procedure on behavioral health services and psychotropic medication use.

Upon admission, residents with psychiatric diagnoses will have psychiatric/psychological evaluation ordered. IDT will ensure that evaluations will be carried out

IDT team will discuss current residents who start to exhibit behaviors to determine the degree of severity, distress and potential safety risk to the resident and develop plan of care accordingly.

PERFORMANCE MONITORING

The Director of Nursing (DON)/QA will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

COMPLETION DATE: 8/23/2024

F755

CORRECTION ACTION

On 7/23/2024, the DON contacted the MD for clarification of strength and dose of medication.

On 7/24/2024, the DON contacted in services with LVN 1 on clarifying strength.

Resident 1 was assessed for constipation or diarrhea. None noted

OTHER RESIDENT AFFECTED IDENTIFICATION

On 8/16/2024 DON/HID audit all residents with order for liquid docusate sodium to ensure strength and dose of medication on a physician order. There are 6 residents on docusate liquid, all ordered has strength and dose of medication. No other residents were affected.

MEASURES AND SYSTEMIC CHANGES

On 7/24/2024, 7/31/2024 and 8/13/2024 the DON conducted inservice to Licensed nurses on facilty's policies titled "Medication and treatment orders" and "administering medication" with emphasis that all medication orders must include the strength of the medication and that if it does not, to contact the resident's physician

Upon admission, and with new orders, Licensed nurses will ensure all resident orders for liquid docusate sodium strength of medication.

HID will conduct audit of TO orders on a daily basis to ensure all medication orders include strength.

The Nursing Team will conduct a monthly 3-way med check for all residents to ensure all ordered medication includes the strength of the medication.

PERFORMANCE MONITORING

The Director of Nursing (DON)/QA will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

COMPLETION DATE: 8/23/2024

F761

CORRECTION ACTION

On 7/25/2024, the DON conducted 1:1 with LVN 1 on policy titled medication labeling and storage with emphasis on ensuring medications and cart are not left unattended when open.

On 7/24/2024 DON conducted 1:1 with LVN 4 on policy titled medication labeling and storage with emphasis on open dates and multidose vials to be discarded after 28 days from open date.

On 8/16/2024, the DON conducted an audit of residents 77 MAR to ensure all medication had been given.

OTHER RESIDENT AFFECTED IDENTIFICATION

On 8/16/2024, the DON conducted audit on eMAR for all residents under the care of LVN 1 on 7/23/24 to ensure no missed medication. No other residents were affected.

On 7/23/2024, the DON conducted audit of all insulin to ensure no other insulin contained two open dates and that all insulin were within 28 days of open date. No other residents were affected.

MEASURES AND SYSTEMIC CHANGES

On 7/31/2024, 8/13/2024 and 8/16/2024, DON conducted in-service to all LN on facility policy titled "medication/ labeling and storage" with emphasis on ensuring medication and carts are not left unattended and with emphasis on opened dates on multidose vials.

Upon hire and annually and as needed, skills competency will be conducted on LN

DON to conduct random spot check on 8/1/2024 licensed nurses to ensure med carts are not left unattended and that open vials contain one open date and are discarded after 28 days from open date.

All Licensed nurses will educate on proper medication labeling and storage with emphasis on open dates and multidose vials to be discarded after 28 days from open date.

The Pharmacy Nurse will conduct random checks on each cart during Monthly visit to ensure the medications are labeling and storage with emphasis on open dates and multidose vials to be discarded after 28 days from open date.

PERFORMANCE MONITORING

The Director of Nursing (DON) will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

The Administrator will discuss at the monthly QAPI meeting any trends or concerns for further evaluation of the program and recommendation x 3 months or until substantial compliance is obtained.

COMPLETION DATE: 8/23/2024

F802

CORRECTION ACTION

DSD confirmed DA 1 had Cook/Kitchen competency conducted on 12/11/2023

On 8/16/2024, RD conducted 1:1 with DA1 on manufacturers guidelines for QT-40 with emphasis on need to leave testing strip in solution for 10 seconds before removing and that sanitation level should be at 200 PPM

OTHER RESIDENT AFFECTED IDENTIFICATION

On 7/26/2024,The DON conducted audit on all changes of conditions 7/24/24 and 7/25/24 to ensure that no COC was related to food-borne illness. No residents were affected by the deficient practice.

MEASURES AND SYSTEMIC CHANGES

On 8/16/2024 Registered Dietician conducted competency on Dietary aide related to QT-40

Upon hire, annually and as needed, DS will conduct skills competency on all Dietary aides on QT-40

DSS/RD will conduct weekly x 3 months observation of Dietary aides who are conducting QT-40 sanitation

Follow up education will be provided to any dietary aide as needed

PERFORMANCE MONITORING

The Administrator/Designee will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

COMPLETION DATE: 8/23/2024

F812

CORRECTION ACTION

On 7/22/23 cook 1 immediately discarded the opened package of cookies.

On 7/23/23 and 8/16/2024, the IP conducted 1:1 in-service with cook 1 and Dietary staff on policy and procedure on hand hygiene.

OTHER RESIDENT AFFECTED IDENTIFICATION

7/26/2024, The DON/HID conducted audit on all changes of conditions 7/24/24 and 7/25/24 to ensure that no COC was related to food-borne illness. No residents were affected by the deficient practice.

MEASURES AND SYSTEMIC CHANGES

On 8/16/2024, the RD conducted Inservice with all dietary staff on facility policy and procedure titled Food receiving and storage with emphasis that all dry foods that are opened should be repackaged and dated with the open date to prevent food from spoilage or contamination.

On 7/24/2024 and 8/16/2024, the IP conducted Inservice with all dietary staff on facility policy and procedure titled Handwashing/Hand hygiene with emphasis on performing hand hygiene practices to prevent cross contamination.

Upon hire, annually and as needed, skill competency will be conducted on all dietary staff on food receiving and storage and hand hygiene.

On a weekly basis, DSS/RD/Designee will conduct rounds of pantry to ensure all opened packages are repackaged and dated with open date.

On a weekly basis, DSS/RD/Designee will observe kitchen staff to ensure hand hygiene is being performed routinely.

On 8/16/2024, the IP will conduct spot check observation of dietary staff to ensure hand hygiene is being conducted properly and every Wednesday weekly x 3 month.

PERFORMANCE MONITORING

The Director of Nursing (DON)/Designee will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

COMPLETION DATE: 8/23/2024

F880

CORRECTION ACTION

Cloth gait was immediately replaced with plastic gait belt by rehab. Facility will discard all cloth gait belt.

Residents 85 urinal was immediately removed from the trashcan and provided urinal holder. A new urinal was provided to the resident on 7/22/2024.

IP discussed with resident regarding using a urinal stand to properly store the urinal to prevent any infection

DON conducted 1:1 in-service with LVN 1 on 7/23/2024 to disinfect countertop and medication trays between resident room visits.

OTHER RESIDENT AFFECTED IDENTIFICATION

All resident in the facility have the potential to be affected by the alleged deficient practice. The DON/DOR provided plastic gait for all RNA.

Onn 7/22/24, The IP/DSD/Department heads make rounds ensure urinal was properly store and provided urinal holder. No other residents were affected.

MEASURES AND SYSTEMIC CHANGES

In-service RNA regarding infection prevention with emphasis on how to properly clean gait belts every before and after use.

On 8/20/24, The DON Inservice the RNA regarding use of plastic gait belt only in all patients and disinfect before and after use.

1:1 in-service with RNA 1 on cleaning and disinfecting shared equipment properly.

IP conducted 1:1 with CNA to use urinal stand for proper urinal storage to prevent any infection.

On 7/31/2024, the DSD conducted in-service with nursing staff regarding infection prevention with emphasis on use of urinal stand to hold urinals while not in use

On 7/23/2024, 7/31/2024,8/13/2024 and 8/16/24 the DON/DSD/IP Conducted in-service with LN, Dietary, CNA/RNA on infection prevention and control with emphasis on need to wipe down countertop and medication trays in between use and Hand hygiene.

Upon daily room rounds, department managers will ensure urinals are placed in urinal stand when not in use

IP will conduct random observation each week of RNA to ensure gait belts are being disinfected in between use

DON will conduct random observation during med pass to ensure trays are being disinfected in between use.

PERFORMANCE MONITORING

The Director of Nursing (DON)/IP will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

COMPLETION DATE: 8/23/2024

F911

CORRECTION ACTION

On 7/22/2024 The administrator submitted request for a waiver on five-bedroom accommodation for room 106 to the Department of Health for review and approval.

OTHER RESIDENT AFFECTED IDENTIFICATION

No resident was directly affected by five-bedroomed accommodation in the room. The room has ample space for each of the residents and their wheelchair and medical equipment needed.

MEASURES AND SYSTEMIC CHANGES

The facility staff will ensure ample space is continuously available and maintained for the five residents in the waiver room 106. Any negative findings will be reported to the CEO for further follow through.

The Administrator will monitor compliance.

PERFORMANCE MONITORING

The Administrator will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

COMPLETION DATE: 8/23/2024

F925

CORRECTION ACTION

Trash was thrown inside the big bin and small bins removed and are not in use anymore.

OTHER RESIDENT AFFECTED IDENTIFICATION

COCs audited for any infection outbreak.

MEASURES AND SYSTEMIC CHANGES

On 8/13/2024, In-service housekeeping staff/environmental aide on policy and procedure titled Pest control with emphasis on covering trash bins and not letting trash accumulate.

Environmental rounds by Maintenance Director to ensure trash bins are not overflowing and covered.

Pest control comes every week or as needed,

PERFORMANCE MONITORING

The Administrator/Maintenance supervisor will provide a summary trend analysis of negative findings to the QAPI Committee meeting. If there are no negative findings reported after 1 quarter, the issue is considered resolved.

COMPLETION DATE: 8/23/2024