POC Accepted on 5/20/2024 By 48029

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

PRINTED: 05/07/2024
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
	055161	A. BUILDING _____ B. WING _____	C 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN CREST REHABILITATION CENTER	909 LUCILE AVE. LOS ANGELES, CA 90026

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of one complaint investigation. Complaint Number: CA00895581. Representing the Department: HFEN 48026. The inspection was limited to the one complaint investigated and does not represent the findings of a full inspection of the facility. Two deficiencies found for complaint Number: CA00895581 (Refer to F726 and F755).	F 000	The following are the plans of corrections for Garden Crest Rehabilitation Center regarding the statement of Deficiencies dated 4/23/2024. This plan of correction is not to be construed as an admission of or agreement with the findings and the conclusion in the statement of deficiencies, or any related sanctions or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective. This plan of correction constitutes my written credible allegation of compliance for the deficiencies noted.	
F 726 SS=D	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	F 726	**F726** **Competent Nursing Staff** **Corrective Action:** LVN4 CPR was renewed and filed on 4/20/24 and was in-serviced on the same day 4/20/24 with the importance of keeping CPR up-to-date with each renewal	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Admin | (X6) DATE 5/13/24

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 726	Continued From page 1 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 assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of two licensed nurses (licensed Vocational Nurse 4 [LVN 4] did not continue to provide care to residents in the facility during the period LVN 4's Cardiopulmonary resuscitation (CPR - is a lifesaving technique that's useful in many emergencies in which someone's breathing or heartbeat has stopped) certification had expired (no longer valid). This deficiency had the potential for LVN 4 not to stay up to date on the latest CPR techniques and placing the residents at increased risk to experience a decline in health status, function, hospitalization, and death. Findings: During a concurrent observation and record review of LVN 4's CPR card, indicated LVN 4's CPR card had expired on 3/31/2024. During an interview of LVN 4 on 4/22/2024 at 4:04 PM, LVN 4 acknowledged that LVN 4's CPR card expired on 3/31/2024. LVN 4 stated LVN 4 took a CPR class on 4/19/2024 but had not yet received	F 726	On 5/08/24 DON conducted a 1:1 in-service with DSD regarding job description such to train staff, organize, develop and implement all in-services education to assure resident safety DON will plan to conduct random audit with DSD Competency skill monthly beginning 4/26/24 x3 **Identification of other residents and Corrective Action:** A complete all facility employee file audit was done by DSD on 4/23/24 no other staff were affected by this deficient practice. On 5/08/24 DON along with DSD conducted an inservice to Licensed nurses and certified nurses aids on Policy and Procedure regarding Competency and Skill check DSD created a lesson plan and question/answer test as she will be utilizing monthly starting 4/20/24 The facility will provide monthly, quarterly and yearly competency and skill check to staff Beg. 5/16/24	

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F 726	Continued From page 2 the renewed CPR card via email but will follow-up. LVN 4 stated facility's Director of Staff Development (DSD - responsible for planning and implementing the facility's orientation and educational programs for all employees) reminded her "sometime in March 2024" about getting the CPR card renewed. LVN 4 stated LVN 4 made a mental note when to get the CPR renewed, but "was just late in getting it done." LVN 4 stated LVN 4 continued to work in the facility after LVN 4/s CPR card had expired. LVN 4 stated LVN 4 was scheduled to return to work in the facility on 4/23/2024. When asked why it is important to renew a CPR card, LVN stated LVN 4 may miss out on new CPR information. During an interview with DSD on 4/22/2024 at 4:14 PM, DSD stated sometime in 3/2024, she reminded LVN 4 her CPR card will expire on 3/31/2024. DSD stated DSD did not follow up to ensure LVN 4's CPR card was renewed. DSD stated CPR card must be current, so nurses know the latest technique in performing CPR. During an interview with Director of Nursing (DON) on 4/23/2024 at 11:31 AM, DON stated, "all staff including (Registered Nurses [RN], LVN, Certified Nursing Assistants [CNA]) must have current a CPR card when performing nursing tasks, if not, the staff cannot work until they do." A review of the facility's 4/2024 schedule, indicated, LVN 4 worked on the following days after LVN 4's CPR card expired on 3/31/2024 and worked on 4/1/2024 - 4/5/2024, 4/7/2024 - 4/10/2024, 4/14/2024 - 4/16/2024, and 4/20/2024 -4/21/2024. A review of the facility's 4/2024 schedule,	F 726	**Measures to prevent recurrences** The facility will provide monthly, quarterly and yearly competency and skill check to staff beginning 5/16/24 DSD will do competency skill check to all newly hired staff in the facility Beginning 5/16/24 **Monitoring performance integration into quality assurance system:** DON will randomly audit DSD with Nursing competency skill check on 5/16/24 to ensure that staff have completed all necessary training required with all skills check. Findings and trends will be discussed during Quality Assurance and Performance Improvement (QAPI) Committee meeting monthly recommendations for 3 months. Completed as of 5/16/2024	

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F 726	Continued From page 3 indicated, LVN 4 worked from 7 AM to 3 PM on 4/1/2024 - 4/5/2024, 4/7/2024 - 4/10/2024, 4/14/2024 - 4/16/2024, and 4/20/2024 -4/21/2024. A review of the facility's 4/2024 schedule, indicated, LVN 4 worked from 11 PM - 7 AM shift on 4/04/2024. A review of the facility's 4/2024 schedule, indicated, LVN 4 worked a double shift from 7 AM - 3 PM, and 3 PM - 11 PM) on 4/16/2024. A review of the facility's LVN job description dated October 2020, indicated, "nurses who provided nursing services have the skills, experience and knowledge to do a particular task or activity which includes proper licensure and certification, if required."	F 726		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755	**F755** **Pharmacy Srvcs/Procedures/Pharmacist/Records**	

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F 755	Continued From page 4 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure licensed nurses documented that: 1) 26 of 26 medications were administered on residents' medication administration record (MAR - a report detailing the drugs administered to a patient by a licensed healthcare professional at a facility) for Residents 2, 5, and 9. 2) Eight of Eight removed narcotic medications on the controlled drug record (narcotic sheet - a document to track the administration of controlled substances [narcotic medications which have a potential for abuse and may also lead to physical or psychological dependence]) for Residents 2, 5, 8, and 9. 3) The blood pressures (BP) were taken and or readings recorded prior to the administration of BP medications for Residents 2, 5. These deficiencies had the potential to: 1. Misrepresent the actual medications administered to residents, 2. Undercount the actual narcotics taken,	F 755	**Corrective Action:** On 4/23/24 1:1 in-service with LVN10 regarding charting and documentation all medication administered are to be documented in the resident's MAR and documentation will be complete and accurate On 4/23/24 1:1 in-service with LVN4 regarding charting and documentation, all medications administered are to documented in the MAR and documentation will be complete and accurate. Initiate vital sign when necessary and verified for each resident prior to administering medications, record the date, time, dose route of administration sign and title on MAR. On 4/23/24 1:1 in-service with LVN5 regarding charting and documentation. All medications administered are to be documented in the resident's MAR and documentation is accurate	

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F 755	Continued From page 5 residents may receive double doses of medications, and 3. 3. Misrepresentation of the narcotic medication inventory on hand on each shift. Findings: A review of Resident 8's admission record indicated Resident 8 was admitted on 6/21/2021 with the diagnoses of chronic obstructive pulmonary disease (a chronic inflammatory lung diseases that causes obstructed airflow from the lungs), acute and chronic respiratory failure with hypoxia (the respiratory system cannot adequately provide oxygen to the body leading to insufficient amount of oxygen at the tissue level), and supraventricular tachycardia (a condition where the heart suddenly beats much faster than normal). A review of Resident 8's history and physical (H&P - a physician's first complete patient examination) dated 01/18/2023, indicated, Resident 8 was interactive and answered questions appropriately. A review of Resident 8's Order Summary Report (a list of all types of physician orders) with an order and start date of 12/21/2023, indicated, diltiazem should be held for systolic BP (SBP - the top number on a BP measures the pressure in the arteries when the heart beats) of less than 100 or HR of less than 60. A review of Resident 9's H&P dated 2/27/2024, indicated Resident 9 does not have the capacity to understand and make decisions. A review of Resident 9's admission record	F 755	On 4/23/24 1:1 in-service with LVN8 regarding charting and documentation, all medication administered are to be documented in the residents MAR and documentation will be complete and accurate. Proper documentation of controlled substance recording the time, date and methods of administration of medications indicate vital signs on MAR when necessary and verified for each resident prior to administering medication, record the dose, time, route of administration. **Identification of other residents and Corrective Action:** Residents have the potential to be affected by this deficient practice. On 4/24/24 Registered Nurse Supervisor will do random checks daily to ensure proper charting and documentation of MAR are completed in the resident medical records. All controlled substances were recorded accounted for by licensed nurse and all vital signs were recorded and verified on MAR. Starting 4/27/24 Medical Records will do weekly audits to ensure charting and documentation on all resident's medical records, all controlled	

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F 755	Continued From page 6 indicated, Resident 9 was admitted on 2/28/2024 with the diagnoses of cerebral infarction (damage to the tissues in the brain due to loss of oxygen to the area), and hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness or the inability to move one side of the body, making it hard to perform everyday activities)following cerebral infarction. A review of Resident 9's Minimum Data Set (MDS - a required standardized assessment and care planning tools), dated 3/05/2024, indicated, Resident 9 had severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). A review of Resident 2's admission record indicated Resident 2 was admitted on 3/12/2024 with the diagnoses of acquired absence of the left toe (amputation of the left toe), type 2 diabetes mellitus (a long-lasting condition when the pancreas does not produce enough insulin or when body cannot effectively use the insulin it produces causing blood glucose [sugar] to go high), peripheral vascular disease (reduced circulation of blood to a body part due to a narrowed or blocked blood vessel), and hypertensive chronic kidney disease (elevated BP cause by kidney disease). A review of Resident 2's Order Summary Report (a list of all types of physician orders) with an order and start date of 3/12/2024, indicated, amlodipine should be held for systolic BP (SBP - the top number on a BP measures the pressure in the arteries when the heart beats) of less than100.	F 755	substance was recorded, documented by the licensed nurses who administered, all vital sign record on MAR will be verified prior to administering medication and are signed by licensed nurse **Measures to prevent recurrences:** On 4/23/24 16 LVN's and 5 RN's were in-serviced regarding proper charting and documentations, medication administration are to be charted in the residents MAR and documentation will be complete and accurate, controlled substance the nurse who administered the medication is responsible, accountable for recording the quantity of the medication remaining and sign indicate vital sign when necessary, verified for each resident prior to administering medication record the time, date, dose and route of administration. If any is misheld, refused or given at the same one that scheduled time the nurse should initial the MAR for the drug and dose. **Monitoring performance integration into quality assurance system:** Director of Nursing along with Medical Records Director to review records with proper charting and documentation,	

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F 755	Continued From page 7 A review of Resident 2's H&P dated 3/13/2024, indicated, Resident 2 had the decision-making capacity. A review of Resident 2's MDS dated 3/18/2024, indicated, Resident 2 was cognitively intact (mental ability to make decisions on activities of daily living). A review of the facility's Room Change form indicated, Resident 2's room was changed on 3/19/2024. A review of Resident 5's admission record indicated Resident 5 was admitted on 3/20/2024 with diagnoses of acquired absence of left toe, atherosclerosis of native arteries of extremities (a disease causing narrowing and hardening of the arteries that supply blood in the legs and feet), essential hypertension (abnormally high BP not caused by a medical condition), and polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body). A review of Resident 2's MAR, dated 3/26/2024 at 2 PM, indicated heparin sodium injection (decreases the clotting ability of the blood and prevent clots from forming), hydralazine (used to treat high BP), and Tylenol extra strength (provides temporary relief of minor aches and pains), were not documented as administered by Licensed Vocational Nurse 8 (LVN 8). The MAR indicated no BP was taken on 3/26/2024 at 2:00 PM, which was required prior to the administration of hydralazine by LVN 8. A review of Resident 2's Weights and Vitals Summary dated March 2024, indicated, no BP was recorded/taken on 3/26/2024 at 2 PM.	F 755	controlled substance vital sign with all properly documented medication were all properly charted reflecting the methods of administration are documented in the residents medical records and signed by LVN. Findings and trends will be discussed during Quality Assurance and Performance Improvement (QAPI) Committee meeting monthly recommendations for 3 months Beginning 4/23/24 Completed as of 5/16/2024	

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F 755	Continued From page 8 A review of the facility's assignment dated 3/26/2024 for the 7 AM - 3 PM shift, indicated, LVN 8 was assigned to care for all residents in Station B nurse's station, including Resident 2. A review of Resident 8's MDS dated 3/28/2024, indicated, Resident 8 was cognitively intact. A review of Resident 5's Order Summary Report with an order date of 3/31/2024 and start date of 4/01/2024, indicated, amlodipine (Medication to treat/control high blood pressure) should be held for SBP of less than 100. A review of Resident 9's MAR for 3/2024 and 4/2024, indicated, no doses of morphine sulfate (used to treat moderate to severe pain when alternative pain relief medicines are not effective or not tolerated) were administered to Resident 9. A review of Resident 9's narcotic sheet for 3/2024 and 4/2024, indicated, morphine sulfate was not taken/removed from the morphine medication bottle. A review of Resident 2's MAR dated 4/2/2024 at 2 PM, indicated, heparin sodium injection, hydralazine, and Tylenol extra strength were not documented as given by LVN 8. The MAR indicated no BP was taken on 4/2/2024 at 2 PM, prior to LVN 8 administering hydralazine to Resident 2. A review of Resident 2's Weights and Vitals Summary dated April 2024, indicated, no BP was taken on 4/02/2024 at 2 PM. A review of the facility's 7 AM - 3 PM shift	F 755		

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F 755	Continued From page 9	F 755		

assignment dated 4/02/2024, indicated, LVN 8 was assigned to care for all residents in Station B nurses' station, including Resident 2.

A review of Resident 5's H&P dated 4/5/2024, indicated, Resident 5 was, "very sharp and great recall of information" and had the decision-making capacity.

A review of Resident 5's MDS dated 4/06/2024, indicated, Resident 5 was cognitively intact.

A review of Resident 5's Weights and Vitals Summary dated April 2024, indicated, BP of 128/77 was taken on 4/08/2024 at 8:34 AM.

A review of Resident 5's MAR dated 4/08/2024 at 9 AM, indicated, amlodipine (medication that relaxes the blood vessels and lowers BP), aspirin (medication use that is associated with a decreased risk of stroke), polyethylene glycol (used in the management and treatment of constipation), venlafaxine (medication used for the symptomatic treatment of neuropathic [nerve damage] pain), vitamin B12 (supplement - essential for red blood cell formation, nerve function), vitamin D3 (helps body absorbs calcium and phosphorus), chlorhexidine gluconate mouthwash (treats gum disease and for oral hygiene), rivaroxaban (medication used to prevent blood clots and reduces risk of heart attack and stroke), gabapentin (medication used to treat nerve pain and partial seizures), and cephalexin (antibiotic medication used to treat a wide variety of bacterial infections) were not documented as given by LVN 4. The MAR indicated BP was not charted which was required prior to the administration of amlodipine by LVN 4.

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F 755	Continued From page 10 A review of the facility's 7 AM - 3 PM shift assignment dated 4/08/2024 indicated, LVN 4 was assigned to care for all residents in Station B nurses' station, including Resident 5. A review of the facility's Room Change form indicated, Resident 2's room was changed on 4/10/2024. A review of Resident 5's narcotic sheet dated 4/13/2024 at 10 AM and 4/14/2024 at 10 AM, indicated, hydromorphone (a narcotic drug can treat moderate to severe pain) were removed from the blister pack by LVN 8. A review of Resident 5's MAR dated 4/13/2024 at 10 AM and 4/14/2024 at 10 AM, indicated, hydromorphone were not documented as given by LVN 8. A review of Resident 5's narcotic sheet dated 4/16/2024 at 9:31 PM, indicated, hydromorphone was removed from the blister pack by LVN 10. A review of Resident 5's MAR dated 4/16/2024 at 9:31 PM, indicated hydromorphone was not documented as given by LVN 10. A review of the facility's 3 PM - 11 PM shift assignment dated 4/16/2024, indicated, LVN 10 was assigned to care for all residents in Station B nurses' station, including Resident 5. A review of Resident 8's MAR dated 4/17/2024, indicated, Anoro Ellipta Aerosol inhaler powder (medication - an inhaler that relaxes the lung muscles around the airways by opening up to breathe more easily), and budesonide suspension (medication used to prevent difficulty	F 755		

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F 755	Continued From page 11	F 755		

breathing, chest tightness, wheezing, and coughing) were not documented as given by LVN 8. The MAR indicated diltiazem (medication that relaxes the blood vessels, lowers BP, and increase the supply of blood and oxygen to the heart while reducing its workload) was not documented as given on 4/17/2024 at 9 AM and at PM. The MAR indicated BP and HR were not charted which was required prior to the administration of diltiazem by LVN 8.

A review of Resident 8's narcotic sheet dated 4/17/2024 at 1:00 PM, indicated, tramadol (a strong narcotic used to treat moderate to severe pain) was removed from a blister pack by LVN 8.

A review of Resident 8's Weights and Vitals Summary dated April 2024, indicated, no BP and HR were taken on 4/17/2024 at 9 AM and at 1 PM.

A review of the facility's 7 AM - 3 PM shift assignment dated 4/17/2024, indicated, LVN 8 was assigned to care for all residents in Station A nurses' station, including Resident 8.

A review of Resident 2's narcotic sheet dated 4/20/2024 at 5:14 AM, indicated, oxycodone (a narcotic drug helps control persistent or severe pain) was removed from the blister pack (a form of tamper-evident packaging where medications are individually sealed in a bubble) by LVN 5.

A review of Resident 2's MAR dated 04/20/2024 at 5:14 AM, indicated, oxycodone was not documented as given by LVN 5.

During an interview with Resident 2 on 4/20/2024 at 8:42 AM, Resident 2 stated he received "never

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F 755	Continued From page 12 missed" any of his medications, including his heparin sodium injection, hydralazine, Tylenol extra strength, and oxycodone medications. During an interview with Resident 8 on 4/20/2024 at 9:18 AM, Resident 8 stated Resident 8 did not think Resident 8 missed any of her medications. Resident 8 stated nurses always check her BP prior to administration of her "heart medicine." Resident 8 stated Resident 8 takes her heart medicine every day. During an interview with Resident 5 on 4/20/2024 at 10:34 AM, Resident 5 stated, Resident 5 never missed any of her medications, including hydromorphone. Resident 5 stated, "if the nurse forgets to give them to me, I remind her." During an observation of Resident 9's morphine sulfate bottle on 4/20/2024 at 1:35 PM, the morphine sulfate bottle was not sealed and had 27 mL (milliliter - a unit of measure in fluid volume; 1 mL = 0.001 liter) in a 30 mL bottle. During an interview of LVN 1 on 4/20/2024 at 1:35 PM, LVN 1 stated Resident 9's morphine sulfate bottle was not sealed. LVN 1 stated the bottle may have been opened by a nurse who may have administered the medication but did not document, a nurse may have removed the medication from the bottle but at the last minute, decide not to administer the medication. LVN 1 was asked why documentation on the MAR was important. LVN 1 stated administration of medication must be documented or else it was not given. LVN 1 was asked by documentation on the narcotic sheet was important. LVN 1 stated narcotics are controlled substances and nurses are accountable to what narcotic was given or	F 755		

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F 755	Continued From page 13 discarded. LVN 1 stated documentation in the MAR are the narcotic sheet were important to ensure resident did not get medications twice in a short time. LVN 1 stated if Resident 9 did not receive prescribed morphine sulfate when needed, then Resident 9's pain level will increase throughout the day. LVN 1 stated if Resident 9 received morphine sulfate twice in less than 4 hours, Resident 9 may experience dizziness, have low energy, low respiratory rate and BP which may require hospitalization. During an interview of RNS 2 on 4/20/2024 at 2:19 PM, RNS 2 stated morphine sulfate bottle opened meant a nurse may had taken a dose or more from the medication bottle. RNS 2 stated when morphine sulfate was not documented in the MAR as administered or on the narcotic sheet as discarded, it meant the nurse may have administered the morphine or discarded the morphine prior to administration but was not documented. RNS 2 stated if morphine was given twice in less than 4 hours between doses, Resident 9 might respiratory rate and heart rate (HR) decrease so low that Resident 9 may require hospitalization for higher level of care. A review of Resident 9's narcotic sheet for March 2024, indicated Resident 9's morphine sulfate was discarded and signed by two nurses on 4/20/2024. A review of Resident 9's MD order dated 4/20/2024 at 7:22 PM, indicated, Resident 9's morphine sulfate was discontinued. During an interview with LVN 10 on 4/22/2024 at 6:44 PM, LVN 10 stated LVN 10 administered the hydromorphone to Resident 5 on 4/16/2024. LVN	F 755		

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F 755	Continued From page 14 10 stated LVN 10 had forgotten to document hydromorphone as administered to Resident 5. LVN 10 stated if the documentation was late, other nurses might think hydromorphone was not given, Resident 5 will receive double dose of hydromorphone which can lead to overdosing causing Resident 5 dizziness to change in level of consciousness which would require hospitalization. During an interview with LVN 8 on 4/23/2024 at 9:37 AM, LVN 8 stated he administered heparin sodium injection, hydralazine, and Tylenol extra strength on 3/26/2024 at 2 PM and on 4/02/2024 at 2 PM to Resident 2. LVN 8 stated LVN 8 forgot to document the medications as administered on 3/26/2024 and on 4/02/24 to Resident 2. LVN 8 stated when administration of medications on 3/26/2024 and 4/23/2024 were not documented, Resident 2 may potentially receive a dose twice, had the risk of having hypertension (very high BP), increase in pain, and blood clots requiring hospitalization. During an interview with LVN 8 on 4/23/2024 at 9:37 AM, LVN 8 stated LVN 8 administered Anoro Ellipta Aerosol inhaler powder, and budesonide suspension as ordered on 4/17 at 9:00 AM to Resident 8. LVN 8 stated LVN 8 remembered giving these medications because if LVN 8 did not administer the medications, the resident will remind him. LVN 8 was asked if diltiazem was given to Resident 8 on 4/17 at 9 AM and at 1 PM, LVN 8 stated he gave these medications. When asked how remembered giving the medications, LVN 8 stated resident 8 would have reminded him. LVN 8 was shown the April 2024 Weights and Vitals Summary document and acknowledged the BP and HR were not taken	F 755		

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F 755	Continued From page 15 prior to the administration of diltiazem on 4/17/2024 at 9:00 AM and 1:00 PM. LVN 8 stated he forgot to chart the BP and HR, but these vital signs were taken prior to the administration of diltiazem. During an interview with LVN 8 on 4/23/2024 at 9:37 AM, LVN 8 stated LVN 8 gave Resident 5's doses of hydromorphone on 4/13/2024 and 4/14/2024. LVN 8 stated LVN 8 had forgotten to document the hydromorphone as given to Resident 5. LVN 8 stated if the hydromorphone were not given to the Resident 5 on 4/13/2024 and 4/14/2024, Resident 5 would suffer the entire day due to pain, have facial grimacing, and potential to withdraw from activities, not able to sleep or eat or even hospitalized if the pain became unbearable. During an interview with LVN 4 on 4/23/2024 at 2:59 PM, LVN 4 stated LVN 4 gave all 10 medications (amlodipine, aspirin, polyethylene glycol, venlafaxine, vit B12, vit B3, chlorhexidine gluconate mouthwash, rivaroxaban, gabapentin, and cephalexin) to Resident 5 on 4/08/2024. LVN 4 stated LVN 4 had forgotten to document the administration of 10 medications to Resident 5. LVN 4 stated LVN 4 forgot to enter Resident 5's BP as ordered on 4/08/2024 on the MAR. LVN 4 stated if the 10 medications were not administered to Resident 5, Resident 5 would continue to have hypertension, potential for blood lots, increase pain, bleeding gums and may end up in the hospital if the bleeding or blood clots cannot be controlled. During an interview with LVN 5 on 4/23/2024 at 3:45 PM, LVN 5 stated LVN 5 administered the medication, oxycodone, to Resident 2. LVN 5	F 755		

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stated LVN 5 thought LVN 5 had documented the administration of oxycodone as ordered on 4/23/2024 to Resident 2. LVN 5 stated when administration of medication was not documented, Resident 2 would continue to suffer from pain, be uncomfortable, not able to go back to sleep, and not able to eat. LVN 5 stated when Resident 2's pain is too severe, respiration rate may adversely affect requiring a "trip to the hospital."

A review of the facility's policy and procedure (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled "Charting and Documentation" dated July 2017, indicated, medications administered are to be documented in the resident medical record, and documentation will be complete and accurate.

A review of the facility's P&P titled "Controlled Substances" dated November 2023, indicated, the nurse who administered the medication is responsible for recording the time and method of administration. The P&P indicated the nurse administering the medication is responsible for recording the quantify of the medication remaining and the signature of the nurse administering the medication.

A review of the facility's P&P titled "Administering Medications" dated November 2023, indicated, vital signs, when necessary, were verified for each resident prior to administering medications. The P&P indicated, if a drug is withheld, refused, or given at a time other than the scheduled time, the nurse shall initial the MAR for that drug and dose. The P&P indicated, as required, the nurse

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F 755	Continued From page 17 who administered the medications records in the resident's medical records the date, time, dose, route of administration, and the signature and title of the nurse who administered the medications.	F 755		