STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of five Facility Reported Incidents during an annual recertification survey conducted from 11/12/19 to 11/19/19. The facility census was 754 residents. The sample size was 54 residents. The highest Scope and Severity was G. Facility Reported Incidents: 658225 658360 661726 658149 658807 No deficiencies were issued for Facility Reported Incidents 658225, 658360, 661726, 658149 and 658807. Representing the California Department of Public Health: 33819, Health Facilities Evaluator Nurse; 41545, Health Facilities Evaluator Nurse; 40537, Health Facilities Evaluator Nurse; 40886, Health Facilities Evaluator Nurse; 41616, Health Facilities Evaluator Nurse; 40454, Health Facilities Evaluator Nurse; 38066, Health Facilities Evaluator Nurse; 40619, Health Facilities Evaluator Nurse; 17065, Nutrition Consultant; 34975, Nutrition Consultant;	F 000		

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

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 000	Continued From page 1 41166, Pharmaceutical Consultant; 40903, Pharmaceutical Consultant; 27000, Pharmaceutical Consultant.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure psychotropic medication (a medication capable of affecting the mind, emotions, and behavior) was administered with consent of Resident 992 (Res 992) or its authorized agent per facility's policy. The failure had the potential for not honoring resident's right to be informed about his treatment.	F 552		

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F 552	Continued From page 2 Findings: During observation on 11/14/2019 around 3:30 p.m., Resident 992 was walking in the hallway accompanied by his sister and a physical therapist (a licensed professional with skills to help with safe body movements.) Review of the medical records indicated Resident 992 was admitted to the facility on 11/6/19 with the main diagnosis of traumatic brain injury due to a car accident. On 11/6/2019 at 11:41 a.m., Resident 992 was prescribed a psychotropic medication to be used as follows: "Quetiapine (Seroquel) 12.5 mg, every 6 hours as needed for agitation, striking out, physical aggression, restlessness while in bed." Order's duration was stated as "720 hours" which is equal to 30 days. The same order was re-written again on 11/12/2019 at 13:20 with no changes. A 11/15/2019 review of the electronic medical record, indicated that Seroquel (a psychotropic mind altering medication) was administered on the following date and times: 11/06/19 at 17:54 11/07/19 at 08:29 11/09/19 at 22:08 11/10/19 at 21:05 11/11/19 at 17:58 In an interview with Nurse Manager 4 (NM-4) on 11/15/19 at 12:05 p.m., she stated that Resident 992's daughter had been very supportive and involved with her father's care. Resident's daughter had authority to approve use of mind altering medication and signed the consent for its use. She added that the medical doctor had the responsibility to get the consent from the resident	F 552		

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F 552	Continued From page 3 or his daughter. On 11/15/2019, a review of the signed written consent for use of Seroquel, indicated that the daughter signed the consent on 11/12/19 at 12:00 as the resident's representative. In an interview with Physician 3 (MD-3) on 11/15/2019 at 12:15 p.m., she stated Seroquel was prescribed for safety and fall prevention. She added that Resident 992's aggressiveness could not be controlled by a 24 hours' sitter (a sitter is a health care staff that stays with and observe the resident.) Additionally, MD-3 stated that she did not document consent initially when the resident was admitted on 11/6/19. She could not get a hold of the daughter and didn't want the on-call (back up) doctors get the consent from the daughter after hours since they may have not known the Resident 992 very well. A review of medical records on 11/15/2019, indicated MD-3's admission progress note was updated on 11/12/19 at 1:01 p.m. to include the signed consent for Seroquel use. In an interview with Director of Pharmacy on 11/15/2019 at 12:50 PM., she stated that facility's policy was clear and no medications should have been administered if the consent was not in place per policy. She could not show any documentation if the order verification process addressed the consent documentation or guided the nursing staff not to administer without a consent. On 11/15/19, a review of facility policy number 25-10, titled, "Use of Psychotropic Medications" last revised on 5/14/19, indicated "Informed	F 552		

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F 552	Continued From page 4 consent shall be obtained from the resident or resident's legal representative by the physician prior to initiation of psychotropic medications except in an emergency situation when the physical safety of the resident, other residents, staff and visitors may be at risk."	F 552		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of 54 residents was free from verbal abuse, (Resident 708), when one staff (RN 16) told a resident (Resident 708) during care, "Don't ever interrupt my dinner." This deficient practice caused Resident 708 to experience anxiety and depression every time RN 16 cared for him, which prevented Resident 708 from reaching his highest practicable level of well-being.	F 600		

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F 600	Continued From page 5 Findings: During observation and concurrent interview with Resident 708 on 11/12/19 at 10 AM, Resident 708 was lying in bed with a gastric tube feeding (tube placed into stomach, used to supply nutrition, fluids, and medication) hanging on a metal pole on the left side of the bed. Resident 708 stated in a soft, low voice, "I want to talk to you later about staff treatment and advocacy". During a review of the clinical record for Resident 708, document titled "Minimum Data Set" (MDS, a resident assessment tool), dated 10/28/19, indicated Resident 708 was admitted on 7/31/19, with diagnoses that included a history of encephalitis (an inflammation of the brain usually caused by infection) and pain. MDS also indicated Resident 708 had impaired mobility to bilateral (both) upper and lower extremities (arms and legs). MDS indicated a Brief Interview for Mental Status Score (BIMS, a brief cognitive scanner) score of "13", which indicated "cognitively intact" (no problems with remembering, learning new things, concentrating, or making decisions that affect everyday life). During an interview on 11/15/19 at 11:15 AM, Resident 708 stated, "RN 16 fights with me about what time I will get my medications and is late answering my call light." Resident 708 stated he felt intimidated by RN 16 when she answered his call light and stated in a loud, angry voice "don't ever interrupt my dinner". Resident 708 stated he felt ignored by RN 16 because she "doesn't talk to me or look at my face" during care. During an interview with Resident 708, on 11/19/19 at 2:50 PM, Resident 708 stated he felt anxious and	F 600		

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F 600	Continued From page 6 depressed every time RN 16 was assigned as his caregiver. During an interview on 11/18/19 at 2 PM, Nurse Manager 2 (NM 2) stated Resident 708 informed her that he no longer wanted RN 16 to be assigned to care for him because RN 16 "does not talk to him or make eye contact with him during care." During an interview on 11/18/19, at 3 PM, Licensed Vocational Nurse 4 (LVN 4) stated, "I don't feel comfortable working with RN 16. She is mean to all of the staff, not cooperative and doesn't want to listen. " During an interview on 11/18/19, at 3:15 PM, RN 15 stated, about two weeks ago, Resident 708 told her "yesterday this person who was assigned to me is ignoring me because she is not talking to me or looking at me". RN 15 stated, "maybe it was RN 16". During a review of the clinical record for Resident 708, the document titled "Care Plan", dated 8/19/19, under, "Problem: Evidenced Depression", there were no interventions to address depression. Review of the document titled "2019 Mandatory for all: Residents' Rights and Civil Rights (Preservation of Dignity, Including Provision of Dignity, and Abuse Prevention)", dated 2/19, indicated "verbal abuse ...examples: yelling at a resident ...". Review of the document titled "Education Training In-Service Sign- In Record", dated 2/25/19-3/1/19, indicated RN 16 completed "2019	F 600		

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F 600	Continued From page 7 Mandatory for all: Residents' Rights and Civil Rights (Preservation of Dignity, Including Provision of Dignity, and Abuse Prevention)". Policy and procedure titled "Abuse and neglect prevention, identification, investigation, protection, reporting and response", dated 09/10/19, indicated ... "[facility] shall promote an environment that enhances resident well- being and protects from abuse, neglect, exploitation of residents ... abuse may result in psychological, behavioral, or psychosocial outcomes ... Depression ...".	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 §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	F 656		

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F 656	Continued From page 8 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop care plans for resident specific care concerns for four of 35 sampled residents (Residents 71 Resident, 196, Resident 630, and Resident 685) when: 1. Non-English speaking Resident 71 did not have a person-centered communication care plan and Resident 71's diabetes care plan did not include measurable objectives for blood glucose (sugar) levels. 2. Resident 196 did not have a person-centered care plan to address management of prostate enlargement (prostate gland enlargement that can cause urination difficulty). 3. No person-centered care plan was developed for the management of indwelling urinary	F 656		

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F 656	Continued From page 9 catheters (a tube left in the bladder to carry urine from the bladder to outside the body) for Resident 630 and Resident 685. These failures increased the potential for Resident 71, Resident 196, Resident 630, and Resident 685 to not receive treatment and/or care according to their needs and placed the residents at risk for harm or adverse consequences. Findings: 1. A review of Resident 71's admission records indicated she was admitted to the facility on 5/2/19 with admission diagnosis of vascular dementia (disease of the brain causing symptoms such as loss of memory, judgement, ability to communicate and solve problems, and interference with daily functioning). During an interview on 11/14/19 at 3:02 p.m., Patient Care Assistant (PCA) 1 stated, "Resident [71] doesn't speak English, she speaks Russian, we use communication board ...she gets a little agitated when you don't understand her, I talk to her in a nice way and she doesn't get upset ...If she doesn't know person, its hard ...she tries to grab people ..." During an interview on 11/15/19 at 10:06 a.m., Registered Nurse (RN) 1 stated, "communication is the problem for us ... she spoke English before but since she got sick, she doesn't speak English ... we have translate board in her room, use body language, call translator center 40999, call family ..." A review of Resident 71's communication care plan indicated, "Interventions: 1. Encourage	F 656		

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F 656	Continued From page 10 communication and provide alternate methods of communication as needed 2. Collaborate with Speech Therapy, case management/social services for discharge needs 3. Include patient/family/caregiver in decisions related to communication 4. Decrease background noise 5. Speak up to be heard by patient, direct simple terms ..." During a concurrent interview and record review on 11/15/19 at 10:52 a.m., RN 1 validated Resident 71 did not have a resident centered communication care plan. RN 1 stated, "No resident specific interventions in communication care plan, it's supposed to be in care plan ... yes, it's hard for PCA [patient care assistant] or licensed nurse to take care for patient if interventions not in care plan... if no one understands her, she might get frustrated and get unwanted behaviors ..." During an interview on 11/15/19 at 12:55 p.m., Nurse Manager (NM) 1 stated, "There is a communication care plan but yes resident centered communication care plan would be helpful ... resident not heard or understood which affects resident, frustration and triggers behaviors ..." The facility's policy titled, "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)" revised 7/9/19 indicated, "The Resident Care Plan (RCP) shall be person-centered, evaluated during weekly or monthly summaries, when indicated for short term problems, every quarter, and revised as needed to serve as an essential resource for improved resident outcomes ...purpose: to promote the resident's highest possible physical,	F 656		

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F 656	Continued From page 11 mental and psychosocial [taking into account social factors and person's thoughts and behaviors] well-being ..." A review of the physician's current orders indicated Resident 71 was prescribed: "Levemir® (man-made insulin to control blood sugar) 10 units subcutaneously (underneath the skin) twice daily in the morning and at bedtime. Hold for glucose <110 Metformin [medication to control blood sugar] 1,000 mg (milligrams- unit of measure) orally twice daily with meals. On glucocheck [blood test to check blood sugar levels] days hold for glu [glucose] <110" A review of Resident 71's clinical records indicated the following blood sugar levels: 8/1/19 11:22 glucose, fingerstick (fs) 280, 8/13/19 5:47 glucose (fs) 264, 8/24/19 17:03 glucose (fs) 239, 9/8/19 16:24 glucose (fs) 203, 9/11/19 16:44 glucose (fs) 263, 9/12/19 18:09 glucose (fs) 184, 9/18/19 16:35 glucose (fs) 208, 9/20/19 16:47 glucose (fs) 196, 9/22/19 8:20 glucose (fs) 186, 9/27/19 16:27 glucose (fs) 181, 9/28/19 16:25 glucose (fs) 197, 9/30/19 17:27 glucose (fs) 199, 10/3/19 16:51 glucose (fs) 248, 140/9/19 10:36 glucose (fs) 223, 10/13/19 17:49 glucose (fs) 218, 10/15/19 17:42 glucose (fs) 182, 10/16/19 9:28 glucose (fs) 185, 10/19/19 11:18 glucose (fs) 236, 10/21/19 10:01 glucose (fs) 186, 10/23/19 9:05 glucose (fs) 203, 10/26/19 10:32 glucose (fs) 218, 11/2/19 9:30 glucose (fs) 196, 11/3/19 18:04 glucose (fs)197, 11/6/19 7:47 glucose (fs) 205, 11/12/19 18:59 glucose (fs) 202, 11/13/19 17:53 glucose (fs) 230 A review of Resident 71's diabetes care plan indicated, "Goal: Glucose maintained within	F 656		

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F 656	Continued From page 12 prescribed range.... 3. Administer ordered medications to maintain glucose within target range" During a concurrent interview and record review on 11/15/19 at 9:12 a.m., Registered Nurse (RN) 2 validated Resident 71's diabetes care plan did not include a prescribed range, or measurable objective goal. RN 2 stated, "No blood sugar goal or A1c [blood test that gives information about average blood sugar over past 3 months] goal on care plan ...it doesn't say in policy, panic level has to be determined by doctor and that's when it will appear in care plan. They have not identified a panic level for her..." During a continued interview, RN 2 stated, "The doctors don't have established range when they want nurses to call for high blood glucose levels ...leave it to judgement call of nurses ...Yes, long term damage for high blood glucose over time will be neuropathy, kidney damage, retinopathy ..." During an interview on 11/15/19 at 10:06 a.m., RN 1 stated, "If blood sugar below 110, hold insulin, but on doctor's order it didn't mention when to call if high ... I have to follow up ... I use my knowledge if its above 300 I call the on call [doctor] ... we don't do anything above 200 because no parameter, we don't call ...everyone has different parameter, depends on doctor's order ..." During an interview on 11/15/19 at 12:44 p.m., NM 1 stated, "It would be best for nurses to have range of when to call especially when there isn't a sliding scale [progressive increase in insulin doses based on pre-defined blood glucose ranges] ... unfortunately resident's [71] usual	F 656		

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F 656	Continued From page 13 range or panic levels not in care plan ..." According to the Mayo Clinic, a nationally recognized reference for medical education and research, "Keeping tight control of your blood sugar can help prevent many diabetes-related complications. Long-term complications of untreated hyperglycemia [high blood sugar levels] can include: cardiovascular [heart] disease, nerve damage (neuropathy), kidney damage (diabetic nephropathy) or kidney failure, damage to the blood vessels of the retina [part of the eye] (diabetic retinopathy), potentially leading to blindness, clouding of the normally clear lens of your eye (cataract), feet problems caused by damaged nerves or poor blood flow that can lead to serious skin infections, ulcerations, and in some severe cases, amputation, bone and joint problems and teeth and gum infections." 2. Care of Prostate Enlargement: Resident 196 was admitted on 2/28/18 with diagnoses of dementia (An overall term for diseases and conditions characterized by a decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities), emphysema(A disease involving damage to the air sacs in the lungs. As a result, your body does not get the oxygen it needs), enlarged prostate (Age-associated prostate gland enlargement that can cause urination difficulty). Record review of the most recent quarterly MDS dated 8/15/19 indicated Resident 196 was moderate cognitive impairment, requiring some staff assistance for activities of daily living, was ambulatory and spent most of his time in his bedroom.	F 656		

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F 656	Continued From page 14 Record review of physicians progress note dated 10/22/19 indicated Resident 196 had a urinary tract infection with urinary urgency (A major cause of frequent urination in men is an enlarged prostate that can block the flow of urine, causing the bladder to become irritated and contract infections) that had been treated with antibiotics. During a concurrent interview and review of the electronic record on 11/13/19 at 10:35 AM, RN 10 was not able to identify a care plan addressing the enlarge prostrate of Resident 196 and stated "Yes, we should have one, there might be complications and the possibility of urinary retention..." During an interview with NM 3 on 11/13/19 at 1:55 PM, he acknowledged there was no care plan that addressed care for an enlarged prostate for Resident's 196. NM 3 stated " There should be one...and yes, there is a risk for urinary retention due to enlarged prostrate..." 3. Resident 630 was admitted on 7/01/2005 with diagnoses of diabetes (A group of diseases that result in too much sugar in the blood, high blood glucose), chronic schizoaffective disorder (A mental health condition including schizophrenia and mood disorder symptoms), depression (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), hypertension (A condition in which the force of the blood against the artery walls is too high), neurogenic bladder (Bladder dysfunction (flaccid or spastic) caused by neurologic damage. Symptoms can include overflow incontinence, frequency, urgency, urge incontinence, and retention).	F 656		

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F 656	Continued From page 15 Record review of two Minimum Data Set (MDS), an assessment tool, dated 7/10/19 and 10/10/19 indicated Resident 630 had moderate to severe cognitive impairment, needed extensive assistance from staff for activities of daily living like dressing, eating, and personal hygiene, and used a wheelchair from and to her bed. During an observation on 11/13/19 at 9 AM, Resident 630 was in the dayroom, sitting on a wheelchair, dressed on street clothes. She was unable to verbally respond to a greeting due to her cognitive deficit and had good eye contact. During an interview and record review of the electronic record of Resident 630, with the Registered Nurse (RN 10) on 11/13/19 at 9:12 AM, RN 10 stated "Urinary catheters are placed and changed according to physician's order....". She was able to find an initial physician order dated 7/29/19 for "Foley catheter change every 40 days" (A Foley catheter is a thin, sterile tube inserted into the bladder to drain urine. Because it can be left in place in the bladder for a period of time, it is also called an indwelling catheter). When asked to show documentation of the urinary catheter changes every 40 days, around September 7th and October 17th, RN 10 could not provide evidence of change of catheter according to the physician order, and stated "I can not find when it was changed...I don't know what happened..." During a review of the electronic record of Resident 630 on 11/13/19 at 1:37 PM, RN 10 was not able to find a care plan for the use of urinary catheter including monitoring and maintenance of the catheter. RN 10 stated "I can not find a care	F 656		

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F 656	Continued From page 16 plan...we should have one..." During an interview with the Nurse Manager (NM 3) on 11/13/19 at 1:50 PM, he acknowledged there was no documentation of catheter changes since initial placement and there was no care plan for the use of a urinary catheter, for Resident 630. He stated " I don't know what happened. I think it is an issue related to the recent implementation of the new electronic records system started 3 months ago..." Resident 685 was admitted on 2/16/18 with diagnoses of hypertension, arthritis (Inflammation of one or more joints, causing pain and stiffness that can worsen with age), cognitive impairment (When a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life. Cognitive impairment ranges from mild to severe), gout (A form of inflammatory arthritis that develops in some people who have high levels of uric acid in the blood), and chronic kidney disease. Record review of two most recent MDS dated 10/26/19, an annual assessment, and 7/27/19, a quarterly; indicated Resident 685 was moderately to severely cognitively impaired, required extensive staff assistance on activities of daily living, like mobility, dressing, eating, personal hygiene; was not ambulatory, and used a wheelchair. During an initial tour observation on 11/12/19 at 9: 15 AM, escorted by the Nurse Manager (NM 4), Resident 685 was in bed, sleeping on and off, barely making eye contact, non verbal, cognitively impaired, with an intravenous solution running. A urinary catheter was placed, draining clear urine,	F 656		

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F 656	Continued From page 17 attached with tape to the resident's left leg, a collection tubing hanging on the side of the bed. During a review of the electronic record on 11/12/19 at 10:43 AM, assisted by the Registered Nurse (RN 11), a 11/7/19 11:23 PM physician's "Urgent Visit" progress note indicated "...the patient has not urinated since this afternoon... A physician's order dated 11/8/19 00:07 AM indicated a Foley urinary catheter had been placed. When RN 11 was asked for evidence of care plan for the urinary catheter, she was not able to find one and stated "I can not find a care plan for that (urinary catheter), she [Resident 685] had it (urinary catheter) now for a few days...It seems the RN forgot...Yes, a care plan should be in place for daily care and monitoring..." During an interview with the Nurse Manager (NM 4) on 11/12/19 at 11:55 AM, she acknowledged there was no documentation of a care plan for the urinary catheter of Resident 685. NM 4 agreed there should be one in place "for daily care..." The facility's policy, "Blood Glucose Monitoring", revised 5/14/19, indicated, "When the physician determines blood glucose "panic values," they are to be indicated on the resident care plan. Whenever blood glucose values change from the resident's usual range, or reach the panic value or when the resident's condition is not consistent with the value obtained, the nurse is to repeat the test, assess for symptoms of hypoglycemia [low blood sugar level] or hyperglycemia, treat according to order and inform the physician STAT [immediately]." Record review of a facility policy titled "Nursing Management of Urinary Catheters" indicated	F 656		

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F 656	Continued From page 18 under "Policy...5...Nurses assess indwelling urinary catheters for any blockage, obstruction, or leakage, and monitor residents for any signs and symptoms of catheter associated urinary infections (CAUTI)...8...perform daily catheter care...E. Documentation...4. Plan of Care a. Document initial date of insertion...b. Address possible risk for complications and infections..." The facility's policy titled, "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)" revised 7/9/19 indicated, "The comprehensive care plan shall include measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs ..."	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure two out of four random residents (Resident 698 and Resident 173) were administered topical medication pads up to safety standards. This failure may contribute to medication error or unsafe transition of care in urgent situations. Findings: 1a. During a medication pass observation on	F 658		

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F 658	Continued From page 19 11/12/2019 at 7:40 a.m., licensed Nurse 4 (LVN-4) applied a nicotine patch (a topical patch used to help prevent cigarette smoking) on the shoulder of Resident 698. The nicotine patch was not labeled with date and time of the application. In an interview with LVN-4, he stated that he was not aware of requirement to label the patch with date and time. He was only documenting the location of the patch at the time of administration in the medical record. 1b. During another medication pass observation on 11/14/2019 at 8:05 a.m., Licensed Nurse 5 (LVN-5) applied a lidocaine patch (a topical patch and a numbing agent to treat pain) to Resident 173's knee and back. The lidocaine patch was not labeled with date or time of the application. In an interview with LVN-5 on 11/14/2019 at 8:20 a.m., she stated that there was no requirement by the facility to label the patch when applied to the skin. She added her signature on the Medication Administration Record (MAR-where the nurse records the medication administration) was an adequate documentation. In an interview with Nurse Supervisor 10 (RN-10) on 11/14/2019 at 2:16 p.m., she stated "it's a must" to date and time and to put nursing initials on the outside of the applied patch. It helped with identification just in case the residents got transferred out to the hospital or during urgent situations. On 11/15/2019, a review of facility's policy number J1.0, last revised on 9/10/2019, titled "Medication Administration", indicated a section on "Fentanyl Transdermal (Patch) Application and	F 658		

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F 658	Continued From page 20 Disposal", this section instructed nursing staff to "date and initial patch after application." The policy, however, did not address or included any guidance for nursing staff on how to handle any other types of topical patch.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and	F 676		

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F 676	Continued From page 21 snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility did not provide appropriate treatment and services for one of 35 sampled residents, Resident 547, when needed orthotics shoes were not made available. (Orthotics: They are prescription medical devices like special shoes, to correct biomechanical foot issues such as problems with how you walk, stand, or run. They can also help with foot pain caused by medical conditions). Failure to provide treatment and services is a potential harm risk for residents due to a decline in functioning which negatively impacts on their quality of life. Findings: Resident 547 was admitted on 4/21/16 with diagnoses of traumatic brain injury (Also called TBI, is a sudden damage to the brain caused by a blow or jolt to the head. Common causes include car or motorcycle crashes, falls, sports injuries, and assaults. Injuries can range from mild concussions to severe permanent brain damage), diabetes, hypertension, polysubstance abuse (A person with polysubstance dependence is psychologically addicted to being in an intoxicated state without a preference for one particular substance), chronic kidney condition, and right foot contracture.	F 676		

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F 676	Continued From page 22 Record review of two most recent MDS dated 7/5/19, an annual assessment; and 10/4/19, a quarterly assessment, indicated Resident 547 had good cognition and verbal interactions, and needed only little assistance from staff for activities of daily living like mobility, transfers to and from bed, eating, dressing, and personal hygiene. She used a four wheeled walker (an assistive device with two wheels in front and 2 wheels in back to assist with walking) for ambulation or, at times, a wheelchair. During a review of the electronic record on 11/13/19 at 10:40 AM assisted by RN 10, a 9/19/19 physician's note indicated "[Resident 547]...and drop foot gait who was admitted after 4/8/16 TBI...She has residual problems with walking related to R foot contracture. She was seen by orthotics on 5/16/19 after the contracture in the bottom of her Right foot began to cause some pain with ambulation. They suggested patient might benefit from a custom AFO...Assessment and Plan...Refer to orthotics for consideration of bilateral heel lifts to help level pelvis during ambulation..." (AFO or Ankle Foot Orthotic; a support intended to control the position and motion of the ankle, compensate for weakness, or correct deformities. AFOs can be used to support weak limbs, or to position a limb with contracted muscles into a more normal position). During a review of the electronic record on 11/13/19 at 10:40 AM assisted by RN 10, a 10/10/19 Orthotic physician's note indicated "...The patient [Resident 547] would benefit from an 1 inch heel lift on her right and a corresponding 1 inch full length shoe lift on her	F 676		

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F 676	Continued From page 23	F 676		

left. These shoe modifications will help to ensure patient has a level pelvis and reduce her fall risk. However, these items are not covered by insurance. Plan to is to investigate alternative funding options at this time..."

During a review of the electronic record on 11/13/19 at 10:40 AM assisted by RN 10, a 11/1/19 12:22 PM physician's note indicated "...She [Resident 547] still has a problem walking on her right foot. She has been seen by Podiatry. They recommended AFO...There has been no development with special shoe...Contracture of Right Ankle...Assessment:...Patient is still waiting for her shoes..."

During a review of the electronic record on 11/13/19 at 10:40 AM assisted by RN 10, a "11/11/19 4:56 PM Nursing Monthly Summary Form" that included a review of current care plans, indicated under "ADL Maintenance...Assess and monitor patient barriers to mobility and need for assistive/adaptive devices...9.Provide assistive devices as ordered..."

During an interview with RN 10 on 11/13/19 at 11:40 AM, she stated " The follow up for these orthotic shoes is done by the Social Worker, I can not find any documentation showing what has been done...I don't know what happened..."

During an interview with NM 3 on 11/13/19 at 1:50 PM, after reviewing the documentation in the electronic record of Resident 547 including the physician's notes and the recommendation form Orthotics regarding the need for orthotic shoes, NM 3 acknowledged there was not evidence of documented follow up regarding the AFO and

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F 676	Continued From page 24 stated " Yes, it is usually the Social Worker the one that follows up...I don't know what happened...she missed it..." NM 3 proceeded to page the Social Worker from the nursing station twice, without a response. During an interview with Resident 547 on 11/18/19 at 1:15 PM, she was sitting on a wheelchair next to a table in the dayroom, pleasant and verbally responsive, she stated " Yes, they told me I needed special shoes...I can not walk without those shoes...". When asked if she knew the reason for the delay, she stated "...It has been a long time and I don't know what the problem is..." During an interview with RN 10 on 11/18/19 at 2:05 PM, she stated "The Social Worker is aware now and trying to find a way to provide Resident's 547 orthotic shoes..."	F 676		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700		

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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 700	Continued From page 25 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to obtain informed consents, perform an entrapment risk assessments and develop a care plan before using bed rails (are adjustable metal or rigid plastic bars that attach to the bed) for two of 39 residents (Resident 382 and Resident 465) when: There was no risk assessment or signed consent obtained for Resident 382 before the use of bed rails. There was no risk assessment, signed consent or care plan obtained for Resident 465 before the use of bed rails. These failures had the potential to result in the entrapment (becoming caught by the head, neck or chest in the tight spaces between the bed and bed rails) resulting in injuries to two residents using bed rails. Findings: During an observation on 11/15/19 at 8:50 AM, Resident 382 was observed in bed, with left and right bed rails attached to the top half of the bed, with both in the up position. During an interview with Resident 382 on	F 700		

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F 700	Continued From page 26 11/15/19 at 8:50 AM, Resident 382 stated, "I use it (the bed rail) for turning and positioning." During an interview with patient care assistant (PCA 1) on 11/15/19 at 8:50 AM, PCA 1 stated Resident 382, "always use bilateral ½ bed rails for security." During a review of the clinical record for Resident 382, the documents titled "Bed Rail Safety Assessment, Order Form and Informed Consent" dated 9/6/19, under section "Bed Rail Safety Assessment," the area that indicated "RN Signature," was blank. During a concurrent interview and record review with nurse manager (NM 1) on 11/15/19 at 9:53 AM, NM 1 acknowledged that there should be a nurse signature that indicated an assessment was completed. NM 1 acknowledged that Resident 382 did not have a risk assessment done. During an observation on 11/14/19 at 11:13 AM, the bed of Resident 465 had bed rails in the up position. During a concurrent interview and record review with Risk Management Nurse Supervisor (RMNS) on 11/15/19 at 1:40 AM, RMNS stated, there is no care plan, risk assessment or consent for the use of bed rails in Resident 465 clinical record. During a concurrent interview and record review with Director of Nursing 2 (DON 2) on 11/18/19 at 10:56 AM, DON 2 stated that there is no bed rails risk assessment or a signed informed consent for the use of bed rails for Resident 465. DON 2	F 700		

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F 700	Continued From page 27 stated, "I'm not seeing a consent for bed rails, the original bed rails risk assessment or a care plan." During a concurrent interview and record review with Registered Nurse 17 (RN 17) on 11/14/19 at 12:32 PM, RN 17 stated, that there is no documentation of... an original bed rails risk assessment or a signed informed consent for the use of bed rails in the clinical record of Resident 465. RN 17 stated, "I don't see any of them." The facility policy and procedure titled "Bed Rail Use" dated March 12, 2019, indicated, "...2. Safety assessments shall be completed for residents who use bed rail(s)...4. The Resident or Resident Representative shall consent to bed (side) rail use by signing the informed consent ..."	F 700		
F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a person-centered care plan for 2 of 35 sampled residents (Resident 68 and 71) and 2 random residents (Residents 256 and 327) with dementia (disease of the brain causing symptoms such as loss of memory, judgement, ability to communicate and solve problems, and interference with daily functioning). These failures have the potential for Residents	F 744		

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F 744	Continued From page 28 68, 71, 256 and 327 not to receive the appropriate treatment and services for dementia, preventing Residents 68, 71, 256, and 327 from maintaining their highest level of functioning and enhancing their well-being. Findings: 1a. A review of Resident 68's admission records indicated she was admitted to the facility on 5/9/19 with admission diagnoses of chronic kidney disease (loss of kidney function over time), dementia and dyspepsia (indigestion). A review of Resident 68's physician's progress notes dated 6/5/19 indicated, "Assessments & Plan 1. Vascular dementia without behavioral disturbance ..." A review of Resident 68's Minimum Data Set (MDS- clinical assessment of resident) dated 8/1/19 indicated, " ...Active Diagnoses ...Vascular Dementia without behavioral disturbance ..." A review of Resident 68's MDS dated 11/1/19 indicated, " ...Active Diagnoses ...Vascular Dementia without behavioral disturbance ..." During a concurrent interview and record review on 11/14/19 at 11:40 a.m., Clinical Nurse Specialist (CNS) 1 validated a dementia care plan was not developed for Resident 68. CNS 1 stated, "We should have a care plan that encompasses all aspect of care around dementia ..." During an interview on 11/14/19 at 11:58 a.m., Registered Nurse (RN) 3 stated, "We should have a care plan for dementia on resident ... care plan helps how to note interventions and how to	F 744		

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F 744	Continued From page 29 deal with her [Resident 68's] behavior". 1b. A review of Resident 71's admission records indicated she was admitted to the facility on 5/2/19 with admission diagnosis of vascular dementia. A review of Resident 71's clinical records indicated a resident-centered dementia care plan was not developed or implemented. A review of Resident 71's paper charted dementia care plan dated 5/12/19 indicated, "...staff will provide cues, prompting, demonstration; staff will assist if resident is unable to complete task ...observe, document and report to MD any dementia s/sx [signs and symptoms] ... provide reality orientation as needed ..." A review of Resident 71's electronic dementia care plan dated 10/3/19 indicated, "1. Assess decision making ability 2. Provide a consistent daily routine 3. Assess for mood changes 4. Assess level of sensory function 5. Obtain baseline life history with family members or care givers about routines, likes/dislikes, needs and preferences ..." A review of Resident 256's admission records indicated she was admitted to the facility on 6/13/18, with a care plan for dementia on 5/10/19. A review of Resident 256's clinical records indicated a resident-centered dementia care plan was not developed or implemented. A review of Resident 256's paper charted dementia care plan dated 5/10/19 indicated, "...staff will provide cues, prompting, demonstration; staff will assist if resident is unable to complete task ...observe, document and report to MD any dementia s/sx ...	F 744		

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F 744	Continued From page 30 provide reality orientation as needed ..." A review of Resident 256's electronic dementia care plan dated 8/19/19 indicated, " ...1. Assess decision making ability 2. Provide a consistent daily routine 3. Assess for mood changes 4. Assess level of sensory function ..." A review of Resident 327's admission records indicated she was admitted to the facility on 12/3/18, with admission diagnosis of dementia. A review of Resident 327's clinical records indicated a resident-centered dementia care plan was not developed or implemented. A review of Resident 327's electronic dementia care plan dated 9/26/19 indicated, " ...1. Assess decision making ability 2. Provide a consistent daily routine 3. Assess for mood changes 4. Assess level of sensory function 5. Obtain baseline life history with family members or care givers about routines, likes/dislikes, needs and preferences ..." During a concurrent interview and record review on 11/15/19 at 10:27 a.m., RN 1 validated Resident 71's dementia care plan was general and not resident centered. RN 1 confirmed Resident 256 and Resident 327 also had the same general dementia care plan. During a continued interview on 11/15/19 at 11:05 a.m., RN 1 stated, " ...dementia care plans are supposed to be more specific to know patients and anticipate patients' needs ... If I'm new taking care of patient today, it will be a little bit difficult because I don't know what she likes, her triggers ..." During an interview on 11/15/19 at 1:21 p.m.,	F 744		

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F 744	Continued From page 31 Nursing Director (ND) 1 stated, "Yes they [care plans] should be resident-centered ...it does not help with resident quality of care, need interventions so staff can understand her and she can understand them ..." The facility's policy titled, "Dementia Care" revised 7/9/19 indicated, "Interventions to help decrease behavioral distress in residents with cognitive impairment: a. Person-Centered Care Staff shall ensure a supportive environment that promotes comfort and recognizes the specific needs of the resident as evidenced by the individualized preferences documented in the resident care plan ...."	F 744		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		

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minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and record review, the facility's consultant pharmacist (CP) failed to identify irregularities and make recommendations to the facility for two of 35 sampled residents (Residents 68 and 735) and one random resident (Resident 373) when:

1. For Resident 68, CP failed to identify an inadequate indication for risperidone (an antipsychotic medication to treat severe mental disorder in which thought and emotions are so weak that contact is lost with external reality), and recommend laboratory monitoring;

2. For Resident 735, the CP failed to identify an inadequate indication for risperidone and the lack of gradual dose reduction (GDR, a tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued)

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F 756	Continued From page 33 attempts for use of risperidone; 3. For Resident 373, the CP failed to address benzocaine spray's (a topical anesthetic spray used to numb the skin) safety issues related to the dose, administration and monitoring. The failures resulted in unnecessary medications for the residents and had the potential to place them at risk for harm or adverse consequences. Findings: 1a. A review of Resident 68's admission records indicated she was admitted to the facility on 5/9/19 with admission diagnosis of chronic kidney disease (loss of kidney function over time), dementia (disease of the brain causing symptoms such as loss of memory, judgement, ability to communicate and solve problems, and interference with daily functioning) and dyspepsia (indigestion). A review of the physician's current orders indicated Resident 68 was prescribed risperidone 0.25 mg (milligram- unit of measure) orally daily for paranoia (unreasonable or irrational belief that someone is going to harm you), sundowning (confusion or agitation late in afternoon and evening in persons with dementia), auditory hallucinations (hearing sounds that aren't there). A review of Resident 68's medication admission records (MAR) indicated risperidone was administered from 7/29/19 to 11/14/19. During an interview on 11/14/19 at 1:42 p.m., Licensed Vocational Nurse (LVN) 2 stated Resident 68's targeted behavior monitoring for	F 756		

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risperidone was "wanting to go home" and "hallucinations". LVN 2 stated he never observed Resident 68 experiencing hallucinations.

During an interview on 11/14/19 at 2:30 p.m., Medical Doctor (MD) 1 stated, "She [Resident 68] thinks she is kidnapped. She will speak to you and then in 15 minutes forget ...she came in to facility because she would wake up at 2 in the morning and call 911 because she was scared and did not know where she is ...auditory hallucination needs to be changed because she's hard of hearing ..." MD 1 validated there was no documentation or clinical evidence of auditory hallucinations or paranoia in Resident 68's clinical records.

During an interview on 11/15/19 at 3:00 p.m., Director of Pharmacy (DOP) stated, " ...sundowning is general, we ask that they [physicians] have specific symptoms listed ..."

Risperidone is not indicated for paranoia, sundowning or auditory hallucinations, and contains the following US Boxed Warning: " ...WARNING: INCREASED MORTALITY[death] IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS [mental condition that makes it hard to tell what is reality and what is not reality]... Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death... Risperidone is not approved for the treatment of patients with dementia-related psychosis and has not been studied in this population..."

1b. During a concurrent interview and record review on 11/14/19 at 2:21 p.m., LVN 2 validated

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F 756	Continued From page 35 there was no documented lipid laboratory (labs) orders or results for Resident 68. During an interview on 11/14/19 at 2:30 p.m., MD 1 stated she did not order labs for lipid monitoring. During an interview on 11/15/19 at 3:00 p.m., DOP stated consultant pharmacists were expected to identify if labs were not ordered for residents, and make clinical recommendations to the physicians. According to Lexicomp, a nationally recognized drug reference, monitoring parameters for risperidone include, " ...fasting lipid panel (baseline; repeat 3 months after initiation of antipsychotic; if LDL[low-density lipoprotein-cholesterol that causes fatty build up in blood vessels] level is normal repeat at 2 to 5 year intervals or more frequently if clinical indicated) ..." The facility policy titled, "Policy and Procedure for Medication Regimen Review" dated 06/01/00 indicated, "The Pharmacist identifies irregularities through a variety of sources including ... Laboratory tests ii). Lab tests to monitor the efficacy and/or toxicity of certain medications may be recommended to the physician ..." 2. On 11/14/19, a review of Resident 735's clinical record indicated she was admitted to the facility with diagnoses including vascular dementia (general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain) with behavioral disturbance.	F 756		

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F 756	Continued From page 36 Her current physicians orders included: Risperidone 0.125 mg every morning and 0.25 mg every evening, dated 8/3/19. The record indicated Resident 735 had been on risperidone 0.125 mg every morning and 0.25 mg every evening since admission on 11/6/18. Resident 735 was observed on multiple occasions: on 11/14/19 at 12:25 p.m., 11/15/19 at 9:04 a.m., 11/15/19 10:12 a.m., during which she did not exhibit any types of behaviors. During a concurrent interview and record review on 11/15/19 at 10:12 a.m., registered nurse (RN) 12 said the risperidone was prescribed for "wandering," but she was not aware the resident had any tendency to wander. During a concurrent interview and record review on 11/15/19 at 10:22 a.m., Geriatric Clinical Nurse Specialist 1(CNS 1) confirmed risperidone was prescribed for the behavior of "wandering." She acknowledged the target behavior of wandering was not an appropriate indication for the use of an antipsychotic as dementia patients tend to wander because they may lack understanding or be unfamiliar with their environment. The review also indicated there had been no attempted GDR for risperidone since admission. During an interview on 11/15/19 at 11:18 a.m., Physician 1 (MD 1) said Resident 735 had been on risperidone for "wandering" and had been maintained on the same dose since admission. She agreed the indication of wandering was not appropriate as it did not indicate a danger to the	F 756		

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F 756	Continued From page 37 resident/others or cause significant distress for the resident. MD 1 confirmed there had been no tapering of the dose since admission in 11/2018. She added, "There's no really good excuse for this." During an interview and record review with DOP on 11/15/19 at 12:47 p.m., she said "wandering" was not an adequate indication for the use of risperidone. She added, "It's not effective for that." The DOP was also informed there had been no GDR attempts for the risperidone since 11/6/18. The DOP was asked to provide documents if the CP identified these as irregularities in her report to the facility. On 11/15/19 at 1:34 p.m., DOP said she could not locate any documented evidence the CP identified the inadequate indication and lack of GDR attempts for Resident 735's risperidone in the pharmacy reports. The facility policy titled, "Policy and Procedure for Medication Regimen Review" dated 06/01/00 indicated, "The Pharmacist identifies irregularities through a variety of sources including ...Diagnosis i). A written diagnosis, indication, or documented objective findings to support each medication order. II). Pharmacists shall require clarification of orders for medications prescribed for non-FDA approved uses unless the use is recognized as the community standard, accepted clinical practice or there is literature to support use ..." 3. On 11/14/2019, a review of Resident 373 medical records, indicated an order to use a product called benzocaine 20% spray (a topical anesthetic spray used to numb the skin) which	F 756		

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F 756	Continued From page 38 was ordered to be given as two spray twice a day to the mouth and throat area. Resident 373 had a history of HIV (a viral disease that affects the immune system) and most recently was treated for cancer in the neck area. He was tube-fed (means food and medicine were given to him via a tube connected to his stomach), could not speak, and was quite active moving around the unit on a wheel chair. The medical record, additionally, indicated that he was a candidate for "comfort focused care" (meant no more active treatment of the cancer or surgery and only comfort measures if family or patient agreed upon.) Further review of medical records and the benzocaine order indicated that Pharmacist 3 verified the order and he/she overridden the facility's computer system safety alerts three times and accepted them with the following reason: "Benefit outweighs risk" The alert shown in the electronic medical records was as follow: "Single dose 2 Spray. Overdose (Max. 1 Spray)" A 11/15/2019 review of the Pharmacist 2's drug regimen review documentation in the electronic medical records, titled "30-day Medication Regimen Review Note" on 11/6/2019, indicated "no new recommendations for this month" for Resident 373. In an interview with Director of Pharmacy (DOP) on 11/15/2019 around 10:15 a.m., she provided a pharmacy intervention record dated 10/31/2019, which indicated a clinical pharmacist (a pharmacist that participate in direct resident care)	F 756		

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F 756	Continued From page 39 approved the benzocaine 20% spray use without addressing the safety issues and/or questioning the dose or administration instruction. The order did not give the nursing staff the safety guidelines on administration and monitoring. It was unclear if the physician was updated on safety alerts. A 4/11/2011 safety announcement by U.S. Food and Drug Administration (FDA, a federal agency responsible for protecting the public health by ensuring the safety of drugs and its use) noted the following: "The U.S. Food and Drug Administration (FDA) is alerting healthcare professionals that the agency continues to receive reports of methemoglobinemia, a serious and potentially fatal adverse effect, associated with benzocaine sprays. These sprays are used during medical procedures to numb the mucous membranes of the mouth and throat." https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-continues-receive-reports-rare-serious-and-potentially-fatal A 11/15/2019 review of facility's medication information system (brand name Lexicomp), indicated the following warning: "Methemoglobinemia, a rare but serious blood disorder, reported after topical benzocaine application; reported mostly with use of aerosol preparations during medical procedures (e.g., intubation, endoscopic, or bronchoscopic procedures), but also with topical application of OTC preparations to oral mucosa. Fatalities have occurred."	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		

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F 757	Continued From page 40 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure two of 35 sampled residents (Residents 531 and 735) and one random resident (Resident 373) were free from unnecessary medications when: 1. For Resident 735, the nursing staff did not monitor for signs and symptoms of bleeding for the use of Eliquis (a anticoagulant, or blood thinning medication), and no care plan was developed for its use; there was inadequate laboratory monitoring for the use of levothyroxine (to treat hypothyroidism); and staff did not consistently monitor the heart rate (HR) for the use of carvedilol (cardiovascular medication to	F 757		

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F 757	Continued From page 41 treat high blood pressure that can lower the HR) as stipulated by the facility policy and procedures; 2. Resident 531 was prescribed two laxatives (to loosen stools and increase bowel movements) without hold parameters (instructions for when to hold the medication), resulting in the resident receiving the medications after two episodes of loose stools; 3. For Resident 373, the facility failed to address benzocaine spray's (a topical anesthetic spray used to numb the skin) safety issues related to its use. These failures resulted in unnecessary medications for the residents and had the potential to affect their clinical conditions negatively. Findings: 1a. A concurrent interview and review of Resident 735's clinical record was conducted with Clinical Nurse Specialist 1 (CNS 1) on 11/15/19 starting at 10:41 a.m. Resident 735 was admitted to the facility with diagnoses including atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow) and hypothyroidism (underactive thyroid gland). A review of Resident 735's clinical record indicated she had been on Eliquis (apixaban) 5 milligrams (mg) twice daily for atrial fibrillation since admission on 11/6/18. To date, the Prescribing Information for Eliquis indicates to monitor signs and symptoms of	F 757		

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F 757	Continued From page 42 bleeding such as vomiting blood or vomit that looks like coffee grounds; coughing up blood; blood in urine; black, red, or tarry stools; bleeding from the gums; abnormal vaginal bleeding; bruises without a reason or that get bigger; or any severe or persistent bleeding. (https://dailymed.nlm.nih.gov/dailymed; accessed 11/19/19) During this concurrent interview and review, CNS 1 reviewed the record and could not find any care plans that included goals and interventions for the use of Eliquis. She said there should have been a care plan, and the staff should be monitoring for signs and symptoms of bleeding on a daily basis. She reviewed the clinical record and confirmed there was no documented evidence Resident 735 received daily monitoring for signs and symptoms of bleeding. 1b. The record review with CNS 1 also showed Resident 735 had been on levothyroxine 100 micrograms once daily for hypothyroidism since admission. During the review, CNS 1 said thyroid function laboratory tests should be done at least once yearly. She reviewed the clinical record and said the latest thyroid function tests were conducted on 6/12/18, a year and 5 months ago. During an interview on 11/15/19 at 12:47 p.m., the Director of Pharmacy (DOP) said the thyroid function tests should be done at least once a year for residents receiving levothyroxine. To date, the Prescribing Information for levothyroxine indicates: "When the optimum replacement dose has been attained, clinical	F 757		

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F 757	Continued From page 43	F 757		

(physical examination) and biochemical monitoring may be performed every 6-12 months, depending on the clinical situation, and whenever there is a change in the patient's status. It is recommended that a physical examination and a serum TSH [thyroid-stimulating hormone] measurement be performed at least annually in patients receiving Levothyroxine Sodium Tablets." (https://dailymed.nlm.nih.gov/dailymed/drugInfo; accessed 11/19/19)

1c. Included in Resident 735's drug regimen was a physician order, dated 8/3/19, for carvedilol 25 mg twice daily. The order did not include any instructions for when to hold the medication (such as when blood pressure [BP] or HR is too low). CNS 1 said, for routine cardiovascular medications, the staff was to check BP and HR once a week according to the facility policy. A review of the flowsheet reflected the nursing staff did not consistently monitor the HR on a weekly basis. The flowsheet showed the staff monitored the HR on 10/9/19 and not again until 10/24/19 (15 days later); on 11/2/19 and not again until 11/15/19 (13 days apart).

On 11/15/19, a review of the "Medication Administration" policy, revised 9/10/19, with CNS 1 indicated the staff was to monitor and document in the flowsheet the BP and HR "before each dose, for 7 days, then weekly" and "...hold medication for HR <55."

During the review, CNS 1 acknowledged the nursing staff did not consistently monitor Patient 735's HR on a weekly basis as stipulated by the facility policy.

2. A concurrent interview and review of Resident

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F 757	Continued From page 44 531's clinical record was conducted with Nurse Manager (NM) 7 on 11/14/19 at 1:52 p.m. Resident 531 was admitted to the facility with diagnoses including severe Alzheimer's dementia (a progressive disease that destroys memory and other important mental functions) and had severe cognitive impairment. He was not able to make his needs known, and relied on the staff for all activities of daily living. The clinical record showed the resident had physician's orders for two laxatives as follows: - Senna (relieves occasional constipation) 17.2 mg twice daily, dated 8/21/19 - Sorbitol 70% (used to relieve occasional constipation and irregularity) 30 milliliters once daily, dated 8/21/19. These orders did not include instructions for when to hold the medications. Lexi-comp, a national drug information resource, indicates the side effects for Sorbitol 70% included abdominal distress and diarrhea/loose stools. The record review with NM 7 indicated Resident 531 had two episodes of loose stools on 11/11/19 at 7 p.m. and 9 p.m. However, the medication administration record (MAR) indicated the nursing staff did not hold the two laxatives the next day, on 11/12/19, following those two episodes. The MAR indicated Senna was administered on 11/12/19 at 12: 25 p.m. and 6:23 p.m.; and Sorbitol was administered on 11/12/19 at 12:29 p.m. The following documented bowel movement, on 12/12/19 at 1:36 p.m.,	F 757		

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indicated the resident had "smear" stool appearance.

During the review, NM 7 said it was a standard of nursing practice that the nurse would hold laxatives if the resident experienced loose stools or diarrhea.

During an interview with the Director of Pharmacy (DOP) on 11/15/19 at 1:07 p.m., she said the expectation was that the nurse would hold the laxatives if the resident had an episode of loose stools.

3. On 11/14/2019, a review of Resident 373 medical records, indicated an order to use a product called benzocaine 20% spray(a topical anesthetic spray used to numb the skin) which was ordered as follow:

"benzocaine (Hurricaine) 20% mouth Spray: 2 spray two times daily." The medication was ordered on 10/31/2019 at 08:59 and was available for administration on 11/1/2019.

Resident 373 had a history of HIV (a viral disease that affects the immune system) and most recently was treated for cancer in the neck area. He was tube feed (means food and medicine were given to him via a tube connected to his stomach), could not speak, and was quite active moving around the unit on a wheel chair. The medical record, additionally, indicated that he was a candidate for "comfort focused care" (meant no more active treatment of the cancer or surgery and only comfort measures if family or patient agreed upon.)

On 11/15/2019, a review of the Physician 3's

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F 757	Continued From page 46 (MD-3) progress note dated 10/29/2019 at 4:15 p.m., indicated "Resident is on WC at great room. Not in distress, mumbling voice as usual. Severe dysarthria. C/O right jaw pain 2/10 and mouth pain 3/10." In an interview with the Licensed Nurse 7 (LVN-7) on 11/15/2019 at 08:10 a.m., she stated that she had been administering the benzocaine spray to Resident 373. She did not notice any complaint of oral pain. LVN-7 stated that she cleaned the mouth with swab, then asked the Resident 373 to keep his mouth open so she can spray it in his throat or mouth. She administered two sprays as ordered and could not comment on how long she pushed the spray activator. LVN-7 was not aware of the risks involved if the benzocaine spray was used more than one second since no instruction or guidance was provided by the ordering provider. On 11/15/2019, LVN-7 later accessed the facility's online drug information (Lexicomp- a drug reference database) and noted the following instruction for the administration: "spray for 0.5 seconds by pressing and immediately releasing actuator." She additionally noted the nursing monitoring for "cyanosis, dyspnea and weakness, or tachycardia" due to potential warnings and adverse effects related to inadvertent excessive spraying. A 11/14/2019 review of medical records and the benzocaine order indicated that Pharmacist 3 (Pharm-3) verified the order and he/she overridden the facility's computer system safety alert three times and accepted it with the following reason: "Benefit outweighs risk"	F 757		

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F 757	Continued From page 47 The alert shown in the records was as follow: "Single dose 2 Spray. Overdose (Max. 1 Spray)" In an interview with Director of Pharmacy (DOP) on 11/15/2019 around 10:15 a.m., she provided a pharmacy intervention record dated 10/31/2019 which indicated the pharmacy did not stock the medication initially and later had it available. Additionally, the note indicated that the clinical pharmacist (a pharmacist that participate in direct resident care) approved its use without addressing the safety issues and/or questioning the dose or administration instruction. The order did not give the nursing staff the safety guidelines on administration and monitoring. In an interview with Physician 3 (MD-3) on 11/15/2019 at 12:15 p.m., she stated Resident 373 was on comfort care measures and she was trying to stop his medications, although only chemotherapy (cancer therapy) medications has been stopped so far. She acknowledged pain was not an active issue and resident was actively social despite all his limitations. MD-3 was not aware of safety alerts related to inappropriate use of the benzocaine spray. A 11/15/2019 review of facility's medication information system (brand name Lexicomp- a drug reference database), indicated the following warning: "Methemoglobinemia, a rare but serious blood disorder, reported after topical benzocaine application; reported mostly with use of aerosol preparations during medical procedures (e.g., intubation, endoscopic, or bronchoscopic procedures), but also with topical application of OTC preparations to oral mucosa. Fatalities have occurred."	F 757		

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F 757	Continued From page 48 A 4/11/2011 safety announcement by U.S. Food and Drug Administration (FDA, a federal agency responsible for protecting the public health by ensuring the safety of drugs and its use) noted the following: "The U.S. Food and Drug Administration (FDA) is alerting healthcare professionals that the agency continues to receive reports of methemoglobinemia, a serious and potentially fatal adverse effect, associated with benzocaine sprays. These sprays are used during medical procedures to numb the mucous membranes of the mouth and throat." https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-continues-receive-reports-rare-serious-and-potentially-fatal	F 757		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		

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F 758	Continued From page 49 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure four of 35 sampled residents (Residents 68, 71, 531, and 735) were free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) when: 1. Resident 531 received quetiapine (an antipsychotic medication, to treat severe mental	F 758		

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F 758	Continued From page 50 disorder in which thought and emotions are so weak that contact is lost with external reality) for a wrong indication; 2. Resident 735 received risperidone (an antipsychotic medication) with an inadequate indication; and did not receive any gradual dose reduction (GDR, a tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) attempts for more than a year; 3. Resident 71 received quetiapine without appropriate indication, patient centered non-pharmacological approaches, and adequate behavior monitoring; 4. Resident 68 received risperidone without appropriate indication, patient centered non-pharmacological approaches, and adequate behavior monitoring. The failures resulted in unnecessary medications for the residents and had the potential for medication interactions, adverse reactions, and increased risks associated with the use of psychotropic medications that include but not limited to sedation, respiratory depression, falls, constipation, anxiety, agitation, and memory loss. Findings: 1. Resident 531 was admitted to the facility, in July 2019, with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and dementia (a condition characterized by memory loss) with behavioral disturbance.	F 758		

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F 758	Continued From page 51 The 7/10/19 History and Physical (H&P, a document that gives concise information about a patient's history and exam findings at the time of admission) indicated Resident 531 had diagnoses including severe dementia and "Alzheimer's disease with behavioral disturbance." Nowhere in the H&P did it indicate the resident had bipolar disorder (known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks). A concurrent interview and review of Resident 531's record on 11/14/19 starting at 1:52 p.m. with Nurse Manager (NM) 7 reflected the following physician's order: - Quetiapine 12.5 mg twice daily for "Bipolar Disorder in remission, neurocognitive disorder with behavioral disturbance," dated 10/14/19. Continued record review with NM 7 reflected none of the physicians' progress notes, on 8/5/19, 8/13/19, 9/19/19, 9/25/19, 10/2/19, and 10/10/19, indicated that Resident 531 had bipolar disorder. They indicated she had "neurocognitive disorder due to Alzheimer's disease with behavioral disturbance," for which quetiapine was prescribed. A review of Resident 531's admission Minimum Data Set (MDS, a care area assessment and screening tool), dated 7/22/19, indicated a "No" for the diagnosis of bipolar disorder, meaning he did not have bipolar disorder. During the review and interview above, NM 7 said he was not sure why quetiapine was prescribed	F 758		

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F 758	Continued From page 52 for "bipolar disorder." During an interview on 11/15/19 at 8:14 a.m., physician (MD) 2 said quetiapine was for dementia with behavioral disturbance, that the resident was hitting, pinching, and aggressive towards staff and others. She said the "bipolar disorder" diagnosis "was a mistake on my part" and that the resident did not have a diagnosis of bipolar disorder. On 11/15/19 at 8:40 a.m., the quarterly MDS, dated 10/12/19, was reviewed with the MDS Coordinator (MDSC). Under Section I (active diagnoses) of the MDS, it indicated Resident 531 had a diagnosis of "Bipolar disorder, current episode depressed, mild or moderate severity, unspecified." MDSC said she was surprised to find out the 10/12/19 MDS included bipolar disorder as one of the active diagnoses. She verified Resident 531 did not come in with a bipolar diagnosis. 2. On 11/14/19, a review of Resident 735's clinical record indicated she was admitted to the facility with diagnoses including vascular dementia (general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain) with behavioral disturbance. Her current physicians orders included: Risperidone 0.125 mg every morning and 0.25 mg every evening, dated 8/3/19. The record showed Resident 735 had been on risperidone 0.125 mg every morning and 0.25 mg every evening since admission on 11/6/18.	F 758		

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F 758	Continued From page 53 Resident 735 was observed on multiple occasions: on 11/14/19 at 12:25 p.m., 11/15/19 at 9:04 a.m., 11/15/19 10:12 a.m., during which she did not exhibit any types of behaviors. During a concurrent interview and record review on 11/15/19 at 10:12 a.m., registered nurse (RN) 12 said risperidone was prescribed for "wandering," but she was not aware the resident had any tendency to wander. During a concurrent interview and record review on 11/15/19 at 10:22 a.m., Clinical Nurse Specialist 1(CNS 1) confirmed risperidone was prescribed for the behavior of "wandering." She acknowledged the target behavior of wandering was not an appropriate indication for the use of an antipsychotic as dementia patients tend to wander because they may lack understanding or be unfamiliar with their environment. The review also indicated there had been no attempted GDR for risperidone since admission. During an interview on 11/15/19 at 11:18 a.m., Physician 1 (MD 1) said Resident 735 had been on risperidone for "wandering" and had been maintained on the same dose since admission. She agreed the indication of wandering was not appropriate as it did not indicate a danger to the resident/others or cause significant distress for the resident. MD 1 confirmed there had been no tapering of the dose since admission in 11/2018. She added, "There's no really good excuse for this." An interview was conducted with the resident's daytime nurse (RN 13) on 11/15/19 at 11:53 a.m., RN 13 said risperidone was prescribed for	F 758		

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wandering. She said she had witnessed the resident wander only one time, but she was "re-directable." RN 13 agreed "wandering" was not a good reason why the resident should be on an antipsychotic medication.

The facility's "USE OF PSYCHOTROPIC MEDICATIONS," revised 5/14/19, indicated, "Residents who have not used antipsychotic drugs are not given these drugs unless the antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record," and "[r]esidents who use antipsychotic drugs shall receive gradual dose reductions... in an effort to discontinue or taper the dosage [of] these drugs."

3a. A review of Resident 71's admission records indicated she was admitted to the facility on 5/2/19 with admission diagnosis of vascular dementia.

A review of physician's current orders indicated Resident 71 was prescribed quetiapine 100 mg (milligrams-unit of measure) orally twice daily with meals for behavior disturbances related to vascular dementia.

A review of Resident 71's medication administration record (MAR) indicated quetiapine was administered from 7/29/19 to 11/14/19.

During an interview on 11/14/19 at 3:02 p.m., Patient Care Assistant (PCA) 1 stated, "Resident [71] doesn't speak English, she speaks Russian, we use communication board ...she gets a little agitated when you don't understand her, I talk to her in a nice way and she doesn't get upset ...If

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F 758	Continued From page 55 she doesn't know person, its hard ...she tries to grab people ..." During an interview on 11/15/19 at 10:06 a.m., when asked about Resident 71's behavioral disturbances, RN 1 stated, " ...she curses in Russian, what the husband says, if she doesn't want something she spits on floor or on you ..." During an interview on 11/15/19 at 12:55 p.m., NM 1 validated Resident 71 was prescribed quetiapine for yelling, kicking, hitting and spitting. NM 1 stated, " ...No, she [Resident 71] doesn't have behaviors to where she's harming herself." During an interview on 11/15/19 at 1:20 p.m., NM 1 validated yelling, kicking, hitting, spitting was not an appropriate indication for quetiapine. Quetiapine is not indicated for yelling, kicking, hitting and spitting, and contains the following US Boxed Warning: " ...WARNING: INCREASED MORTALITY[death] IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS [mental condition that makes it hard to tell what is reality and what is not reality]... Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death... Quetiapine is not approved for the treatment of patients with dementia-related psychosis and has not been studied in this population..." 3b. A review of Resident 71's psychotropic medication behavior monitoring flowsheet dated 8/4/19 to 11/15/19 indicated target behaviors as kicking, hitting, spitting, yelling out. During a concurrent interview and record review	F 758		

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F 758	Continued From page 56 on 11/15/19 at 12:16 p.m., RN 2 stated Resident 71 was prescribed quetiapine for being verbally aggressive in Russian, and trying to hit people. RN 2 stated nurses were expected to document number of episodes of targeted behavior on the behavior monitoring flowsheet. RN 2 validated although nurses documented "yes" to indicate Resident 71 exhibited targeted behavior of "yelling out" on 8/15/19 5:47, 8/28/19 5:35, 9/24/19 22:00, 10/8/19 4:30 and 22:00, nurses did not document number of episodes of yelling for those dates. RN 2 stated, "Putting number of episodes tells you're monitoring, whether intervention is successful, whether it's working, dose adjustment is needed or dose needs to be reduced ..." During a concurrent interview and record review on 11/20/19 at 1:12 p.m., Nursing Director (ND) 1 confirmed Resident 71 did not have adequate behavioral monitoring. ND 1 stated, "Nurses need to document number of episodes ... we can't tell if medication is effective and non-drug interventions are effective." The facility policy titled, "Use of Psychotropic Medications" revised 5/14/19 indicated, "The licensed nurse is responsible for monitoring the effectiveness of psychotropic medications by monitoring the specific target behaviors and documenting in the electronic health record (EHR)." 3c. A review of Resident 71's planned alternative to psychotropic (non-drug approaches) monitoring flowsheet dated 8/4/19 to 11/14/19 indicated, "noise reduction, reduced lighting, toileted, encourage sleeping, offer food/drink, adjust clothing shoes, one to one time, redirect."	F 758		

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F 758	Continued From page 57 During a concurrent interview and record review on 11/15/19 at approximately 12:16 p.m., RN 2 validated the planned alternatives to psychotropic monitoring for Resident 71 were not resident-centered. RN 2 stated, "Planned alternatives to psychotropic are the same for everybody ... we work with what is given to us." A review of Resident 71's care plan for behaviors indicated, "Goal: Patient will be free of physical & verbal abusive behaviors ... Interventions: 1. Assess for aggressive behavior 1. Assess ability for self-injury 3. Identify coping mechanisms 4. Assess factors regarding noncompliance ....8. Provide behavioral interventions PRN [as needed] ..." During a concurrent interview and record review on 11/15/19 at 12:55 p.m., NM 1 validated Resident 71 did not have resident centered non-pharmacological behavioral interventions in her care plan. During a concurrent interview and record review on 11/15/19 at 1:12 p.m., ND 1 validated the planned alternative to psychotropic monitoring flowsheet were not resident centered for Resident 71. ND 1 stated, "Non-pharm interventions are not specific, same for every resident, nurse picks from drop down button." ND 1 also validated Resident 71 did not have resident centered non-pharmacological behavioral interventions in her care plan. ND 1 stated, "We wouldn't know what's an appropriate intervention for the Resident [71]." The facility policy titled, "Use of Psychotropic Medications" revised 5/14/19 indicated,	F 758		

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F 758	Continued From page 58 "Non-pharmacological interventions (such as behavioral interventions) shall be the first consideration whenever indicated, instead of, or in addition to, psychotropic medication." The facility policy titled, "Dementia Care" revised 7/9/19 indicated, "Behavioral interventions: Individualized nonpharmacological approaches, including direct care and activities are provided as part of a supportive physical and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities." 4a. A review of Resident 68's admission records indicated she was admitted to the facility on 5/9/19 with admission diagnosis of chronic kidney disease (loss of kidney function over time), dementia, and dyspepsia (indigestion). A review of the physician's current orders indicated Resident 68 was prescribed risperidone 0.25 mg orally daily for paranoia (unreasonable or irrational belief that someone is going to harm you), sun downing (confusion or agitation late in afternoon and evening in persons with dementia), auditory hallucinations (hearing sounds that aren't there). A review of Resident 68's MAR indicated risperidone was administered from 7/29/19 to 11/14/19. During an interview on 11/14/19 at 2:30 p.m. with MD 1, she stated, "She [Resident 68] thinks she is kidnapped. She will speak to you and then in 15 minutes forget ...she came in to facility because she would wake up at 2 in the morning	F 758		

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F 758	Continued From page 59 and call 911 because she was scared and did not know where she is ...auditory hallucination needs to be changed because she's hard of hearing ..." MD 1 validated there was no documentation or clinical evidence of auditory hallucinations or paranoia in Resident 68's clinical records. During an interview on 11/15/19 at 3:00 p.m. with Director of Pharmacy (DOP), she stated, " ...sun downing is general, we ask that they [physicians] have specific symptoms listed ..." Risperidone is not indicated for paranoia, sun downing or auditory hallucinations, and contains the following US Boxed Warning: " ...WARNING: INCREASED MORTALITY[death] IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS [mental condition that makes it hard to tell what is reality and what is not reality]... Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death... Risperidone is not approved for the treatment of patients with dementia-related psychosis and has not been studied in this population..." 4b. A review of Resident 68's clinical records indicated Resident 68 did not have behavioral disturbances with dementia. A review physician's progress notes dated 6/5/19 indicated, "Assessments & Plan 1. Vascular dementia without behavioral disturbance ..." A review of Resident 68's MDS dated 8/1/19 indicated, " ...Active Diagnoses ...Vascular Dementia without behavioral disturbance ..." A review of Resident 68's MDS dated 11/1/19 indicated, " ...Active Diagnoses ...Vascular Dementia without behavioral disturbance ..."	F 758		

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F 758	Continued From page 60 A review of Resident 68's psychotropic medication behavior monitoring flowsheet dated 8/9/19 to 11/14/19 indicated target behaviors as hitting, spitting, delusions, yelling out, and screaming. During a concurrent interview and record review on 11/14/19 at 1:42 p.m., Licensed Vocational Nurse (LVN) 2 stated Resident 68's targeted behavior monitoring for Risperidone was "wanting to go home" and "hallucinations". LVN 2 stated he never observed Resident 68 experiencing hallucinations. LVN 2 stated, "Her [Resident 68] behaviors for yelling out, hitting, and screaming are the same for residents on drop down selection ..." LVN 2 validated target behaviors on Resident 68's psychotropic medication behavior monitoring flowsheet were not accurate or resident centered. During a concurrent interview and record review on 11/14/19 at 2:10 p.m., RN 3 validated yelling, screaming, and hitting were not target behaviors for Resident 68. RN 3 also validate the behaviors were not indicated for the use of risperidone. 4c. A review of Resident 68's planned alternative to psychotropic monitoring flowsheet dated 8/9/19 to 11/14/19 indicated Resident 68's non-pharmacological interventions as, "noise reduction, reduced lighting, medicated for pain, one on one care, back rubbed, movies/tv, toileted, music therapy, pet therapy, activities therapy, changed positioning, encouraging visitors ..." During a concurrent interview and record review on 11/14/19 at 1:42 p.m., LVN 2 validated Resident 68 did not have resident centered	F 758		

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F 758	Continued From page 61 non-pharmacological interventions. LVN 2 stated, "they [non-pharmacological interventions] are not specific, they are all the same ..." During a concurrent interview and record review on 11/14/19 at 2:10 p.m., RN 3 validated non-pharmacological intervention list was general for all residents.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility had a 5.08% error rate when three medication errors out of 59 opportunities were observed during a medication pass when: 1. Resident 727 received two solid medications together via the G-tube (a tube surgically inserted through the abdomen into the stomach to administer nutrition and medications) when they should have been given separately; and also received Senokot (a laxative to loosen stools and increase bowel movements) not in accordance with the physician's order. 2. Resident 173 received an antiviral medication called Tivicay (also known as dolutegravir, it is used to control the infection caused by a virus that attacks the body's immune system and lowers the immunity) not in accordance with the physician's order when it was co-administered	F 759		

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(administered at the same time) with a laxative called senna (or Senokot.)

These failures resulted in medications not given in accordance with the physician's orders and may affect the residents' clinical conditions.

Findings:

1. During a medication pass on 11/13/19 at 8:41 a.m., registered nurse (RN) 11 was observed preparing six medications for Resident 727. Included in the medications were a tablet of Seroquel (an antipsychotic medication) 25 milligrams (mg, unit of measurement) and two tablets of Senokot 8.6 mg. RN 11 was observed placing the Seroquel tablet and the Senokot tablets in individual plastic bags and crushed them separately. She then combined the crushed medications into a cup and dissolved with water.

On 11/13/19 at 8:55 a.m., at the resident's bedside, RN 11 administered the Seroquel-Senokot combo via the G-tube.

Shortly after the medication pass on 11/13/19 at 9:08 a.m., RN 11 said she was told at the employee orientation that she could add the solid medications together when given via enteral tube after crushing them separately.

During a concurrent interview and record review of Resident 727's medical record on 11/13/19 at 11:07 a.m., Nursing Director (ND) 2 said the nursing staff was to crush each medication separately and give them via the enteral tube individually, one by one with flushing of water between each medication. There was no

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F 759	Continued From page 63 physician's order to combine Seroquel and Senokot together. Additionally, the record review indicated Resident 727 had a physician's order, dated 8/21/19, for Senokot 17.2 mg via feeding tube twice daily "Hold for loose stool." A review of the flowsheet indicated Resident 727 had a "large loose stool" at 5 a.m. that morning, on 11/13/19. During another interview on 11/13/19 at 11:15 a.m., RN 11 said she did not check the flowsheet and did not get a report from the morning shift staff regarding Resident 727 having loose stools this morning. She said if she had known, she would have held the Senokot. She agreed the Senokot was not given as ordered. Regarding the combining of Seroquel and Senokot, RN 11 said she was wrong, that she should have given them separately. Under Administration of Medication(s) Through Enteral Tube, the facility's "Medication Administration" policy and procedures, dated 9/10/19, indicated: "Each medication should be administered separately. After each medication flush the tube with 15 mL of water." 2. During a medication pass observation on 11/14/19 at 8:05 a.m., Licensed Nurse 5 (LVN-5) was observed administering morning medications to Resident 173. Included in the medications pass were two tablets of senna 8.6mg and one tablet of Tivicay 50mg which were administered together at the same time. A review of the medical records and Medication Administration Record (MAR- where the nursing staff documented medication administration) on 11/14/2019 accompanied with LVN-5, indicated	F 759		

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LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

(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 759	Continued From page 64 that the MAR instruction for Tivicay asked not to give it concurrently with a laxative. The MAR instruction and order was written as follow: "dolutegravir (TIVICAY) tablet 50mg: give every morning for HIV infection; Give 2 hours before or 6 hours after ... laxatives ..." In an interview with LVN-5 on 11/14/2019 at 8:20 a.m., she acknowledged that she overlooked the instruction on the MAR and she should have asked the pharmacy to separate the administration times of these two medications. On 11/14/2019, a review of facility's policy titled "Medication Administration", last revised on 9/10/2019, indicated a section on "Six Rights of Medication Administration" and the "Right Time" would help with the "Medications requiring special timing to maximize bioavailability or to prevent adverse effects ..."	F 759		
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	F 761		

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F 761	Continued From page 65 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure acceptable labeling, storage requirements and removal of expired medications for 9 random residents (Residents 133, 137, 296, 543, 225, 171, 409, 133 and 42) when: 1. Medications for Resident 42, 225, 296, 543 and non-patient specific medications did not have acceptable labeling requirement; 2. Expired medication for Resident 133, 137, 171, 409 and non-patient specific medications were not removed from active storage area; 3. Medication for Resident 225 was not stored at appropriate storage temperature per manufacturer instruction. These deficient practices had potential for medication error and the use of ineffective medication. Findings: 1a. During an inspection of medication cart 2 at Unit South 2 on 11/12/19 at 11:11 a.m., Resident	F 761		

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F 761	Continued From page 66 296's supply of Symbicort® (medication for decrease inflammation in lung) 160-4.5 inhaler, stored out of the manufacturer's foil pouch in the medication cart, was observed to not have a label with the resident's name, and to not have a date of first use or expiration date documented on the device. During a concurrent interview, Nursing Director (ND) 2 confirmed the observation. ND 2 stated she would not know which resident the Symbicort® belonged to if it was not in the resident's compartment in the medication cart. ND 2 also stated she did not know the expiration date for the Symbicort®. A review of Resident 296's clinical record indicated a physician's order dated 7/31/19 for Symbicort® 160-4.5 inhaler, 2 puffs by inhalation twice daily. A review of Resident 296's Medication Administration Record (MAR) indicated Symbicort® inhaler was administered from 8/3/19 to 11/12/19. According to Lexicomp, a nationally recognized drug reference, "Discard inhaler after the labeled number of inhalations have been used or within 3 months after removal from foil pouch ..." 1b. During an inspection of medication room 2 at Unit South 5 on 11/12/19 at 2:04 p.m., a 250-ml normal saline (mixture of salt and water) IV (Intravenous- into the vein) solution bag stored in the facility's Omnicell (automated dispensing system), was observed out of the manufacturer protective overwrap without an expiration date. In addition, 3 50-ml normal saline IV solution bags and 2 100-ml normal saline IV solution bags stored in the Omnicell, were observed in torn	F 761		

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F 761	Continued From page 67 manufacturer protective overwraps without a date of first use or expiration date. During a concurrent interview, Registered Nurse (RN) 4 stated nurses were expected to date and initial remaining IV solution bags once pouch was torn as well as bags removed the pouch but not immediately used. Nursing Manager (NM) 2 stated she did not know how long the protective pouches for the IV solution bags had been torn or how long the 250-ml IV solution bag had been stored out of the protective pouch. During an inspection of medication room 2 at Unit South 6 on 11/13/19 at 8:12 a.m., a 1000-ml normal saline IV solution bag stored in the facility's Omnicell, was observed out of the manufacturer protective overwrap without an expiration date. In addition, 3 100-ml dextrose 5% (mixture of simple sugar and water) IV solution bags and 1 100-ml normal saline IV solution bag stored in the Omnicell, were observed in torn manufacturer protective overwraps without a date of first use or expiration date. During a concurrent interview, RN 5 stated nurses were expected to date remaining IV solution bags after protective pouch was torn as well as bags removed the pouch but not immediately used. NM 3 stated he was unsure why IV solution bags were in Omnicell if protective pouches were torn. NM 3 also stated IV solution bags should be labeled because nurses could potentially administer expired IV solution bags to residents. During an interview on 11/13/19 at 11:37 a.m., Pharmacist 1 stated, "Overwraps is in our policy and we have a visual sign that says when removing overwraps bags smaller than 50ml get 15 days and bags larger than 50ml get 30 days. We have a yellow sticker where they put date	F 761		

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F 761	Continued From page 68 they open packet, it expires and initials." A review of the facility's policy titled, "Policy and Procedure for Expiration Dating of Pharmaceuticals", dated 02/01/06 indicated, "When the intravenous fluid overwrap is torn or removed any bags that are not used immediately will be dated with a sticker (obtained via central supply). The dating will be 15 days for 25 and 50 ml bags and 30 days for intravenous fluids 100 ml or larger". 1c. On 11/12/2019 between 10:30 a.m. to 02:20 p.m., during an inspection of the medication storage rooms located on 1st and 6th floor of the north building, accompanied by Clinical Nurse Specialist 2 (CNS- 2), Licensed Nurse (LVN-3) and charge Nurse 6 (RN-6), the following unlabeled and undated medications were found in the active storage areas: I. Half used container of topical ointment called Aquaphor (used to treat severely dry skin) with no label or resident's name on it and sitting on the top of medication cart number N1-3; II. A bottle of unlabeled and undated insulin Novolog (type of insulin used to treat high blood sugar) vial in the medication cassette for Resident 543; III. One large jar of Citrucel laxative powder sitting on top of medication cart on the 6th floor N6-3 without a resident name or label; IV. Amber colored liquid bottles labeled as: i. metoclopramide (known as Reglan, drug used to treat nausea and vomiting) for Resident 42 did not have beyond use date (a date that the medication should not be used or	F 761		

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F 761	Continued From page 69 was expired) on the label; ii. gabapentin (known as Neurontin, medication for seizure) and levetiracetam (known as Keppra, a seizure medication) for resident 225 did not have beyond use dates on the label. In an interview with RN-6 and the Nurse Manager 4(NM-4) on 11/12/2019 at 11:58 a.m. and 2:45 p.m. respectively, they both reiterated that the bulk medication containers removed from the stock for single resident use, should have been immediately labeled with patient name and the date it was opened. In an interview with the Director of pharmacy (DOP) on 11/15/2019 at 10:08 a.m., she stated if the original (manufactured provided) bottle not used for liquid dispensing, then the label should have an expiration date per policy. She acknowledged the amber colored medication bottles were not the original container for the products observed in the medication rooms. On 11/15/2019, a review of hospital policy number J 1.1 titled "Obtaining, Handling, and Storage of Medications", last revised on 5/14/2019, indicated "The pharmacist inspects the condition and legibility of labels ..." The policy, however, did not address labeling of the bulk floor-stock items. The same policy indicated "Insulin vials shall be: dated upon initial entry and open vials may be kept in individual resident cassettes ..." 2a. During an inspection of medication cart 4 at Unit South 4 on 11/12/19 at 11:52 a.m., a 50 ml	F 761		

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F 761	Continued From page 70 (milliliter- unit of measure) partially used bottle of famotidine (medication to decrease stomach acid) for Resident 137 was observed to have an expiration date of 11/3/19 in the medication cart. During a concurrent interview, Licensed Vocational Nurse (LVN) 1 and ND 1 confirmed the observation. LVN 1 stated she was going to take it out since it was expired and could have potentially being given. During an interview on 11/15/19 at 1:08 p.m., ND 1 stated nurses are expected to remove expired medication from medication cart and return expired medication to pharmacy. A review of Resident 137's clinical record indicated a physician's order dated 7/30/19 for famotidine 40mg/5ml suspension, 20mg orally at bedtime. A review of Resident 137's MAR indicated famotidine suspension was administered from 11/3/19 to 11/11/19. According to the manufacturer's guidelines, unused famotidine suspension must be discarded after 30 days. A review of the facility's policy titled, "Obtaining, Handling, and Storage of Medications", revised 5/14/19 indicated, "Licensed nurse checks expiration dates of medications before administering medication and on a weekly basis. All unlabeled and expired medications are to be discarded in the medication waste bin." 2b. On 11/12/2019 at 10:30 a.m., during an	F 761		

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F 761	Continued From page 71 inspection of the medication storage rooms located on 1st and 6th floor of the North building, accompanied by Clinical Nurse Specialist 2 (CNS- 2), Licensed Nurse (LVN-3) and Charge Nurse 6 (RN-6), the following items were found to be expired (means no longer appropriate for use): I. Sixteen bags of Saline IV (in to the vein) bag 100mL in the Automated Dispensing Machine (ADM- computerized drug storage and dispensing device) with expiration date of 9/2019; II. One bag of Saline IV bag 500 mL with expiration date of 10/1/2019; III. One bag of D5% NS IV 1 liter (bag with sugar and salt content) expired 7/2019; IV. Purple top blood tubes (tubes used to collect blood sample for lab work) with expiration date of 8/31/2109; V. A large bottle of lactulose liquid (a laxative that also used to reduce the amount of ammonia in the blood of patients with liver disease) for Resident 133 with expiration date of 8/19/2019; VI. A bottle of latanoprost eye drop (also known as Xalatan-eye drop for glaucoma) for Resident 409 which expired on 11/11/2019; VII. A bottle of albuterol inhaler (medication used to help with breathing and asthma) for Resident 171 was expired on 10/23/2019. In an interview with Nurse Manager 6 (NM-6) on 11/14/2019 at 1:13 p.m., he stated that the central supply department was responsible for assuring IV fluid and supplies in the ADM were up to date. He added, that the expired medications should have been removed from the patient medication cassette and returned to pharmacy by nursing staff. In an interview with Director of Pharmacy (DOP)	F 761		

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F 761	Continued From page 72 on 11/15/2019 at 10:00 a.m., she explained how the monthly pharmacist inspections included checking for expiration date. However, the more frequent and ongoing checks were on nursing staff that use the medications on daily basis. On 11/15/2019, a review of hospital policy number J 1.1 titled "Obtaining, Handling, and Storage of Medications", last revised on 5/14/2019, indicated "If drug contents become outdated, contaminated or show deterioration, return to pharmacy for replacement." The policy further noted, "Licensed nurse checks expiration dates of medications before administering medication and on weekly basis. All unlabeled and expired medications are to be discarded in the medication waste bin." 3. On 11/12/2019 at 2:21 p.m., during inspection of the medication storage rooms located on the 6th floor of the north building, accompanied by Charge Nurse 6 (RN-6), a refrigerated medication called gabapentin (also known as Neurontin, used to treat seizure) for Resident 225, was found to be stored at room temperature inside the medication cart storage area. The medication was labeled by pharmacy to "keep refrigerated." In an interview with Licensed Nurse 6 (RN-6), she stated that this could have been an oversight by nursing staff and they may have forgotten to return it to the refrigerator. Review of the product labeling via Food and Drug Administration's approved drug information page called "Daily Med" which was accessed on 11/18/2019 via the following link ,	F 761		

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F 761	Continued From page 73 https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=ee9ad9ed-6d9f-4ee1-9d7f-cfad438df388, indicated to "Store NEURONTIN Oral Solution refrigerated, 2°C to 8°C (36°F to 46°F)."	F 761		
F 802 SS=E	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. 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 facility document review, the facility failed to ensure the competency of two kitchen staff when they did not demonstrate proper procedures for testing sanitizer strength according to manufacturer's directions. This failure had the potential for the sanitizer to be at an improper strength for sanitizing food contact surface areas leading to foodborne illness for a census of 741 residents.	F 802		

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F 802	Continued From page 74 Findings: Review of the undated directions located on the Quaternary Ammonium (Quat) sanitizer solution test strip (strips used to test the strength of the Quat sanitizer solution) container, showed to immerse the test strip in the solution for 10 seconds. On 11/13/19 at 10:12 a.m., in an interview and concurrent observation with Food Service Worker 3 (FSW 3), he stated the shift he covered that day involved the responsibility of cleaning dishes in the 3-compartment sink in an emergency if the dish machine did not work. He stated the third sink would hold a sanitizer solution and it required testing to ensure the proper strength. He demonstrated testing the sanitizer by pouring quaternary ammonium sanitizer solution (Quat) from a hose located above the sink into a red bucket. He dipped a quat test strip into the solution and immediately removed the strip. He stated it read 200 parts per million (ppm) in comparison to the color chart on the test strip container. Then the surveyor asked FSW to retest the solution by holding a test strip in the solution for 10 seconds. He did this and stated the strip read 300 ppm. On 11/13/19 at 10:25 a.m., in an interview with Food Service Worker 4 (FSW 4) and a concurrent observation, FSW 4 stated he was a team leader and one of his tasks was to check the quat sanitizer solution used in the red buckets. The buckets were located in different areas of the kitchen for to sanitize surface areas. FSW 4 demonstrated how to test the sanitizer strength by placing two test strips in an empty cup. Then he filled the cup with Quat solution	F 802		

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F 802	Continued From page 75 and stated he had to wait at least 30 seconds. Then he poured out the solution after a minimum of 30 seconds and stated the test strips at the bottom of the cup were a good strength because they were very dark green. In an interview on 11/13/19 at 11:28 a.m., the Director of Food Service (DFS) confirmed the position FSW 3 worked, which involved rinsing pots and pans was also responsible for washing items in the 3-compartment sink if the dish machine did not function. DFS also stated all staff were expected to know the procedures for using the 3-compartment sink and testing sanitizer.	F 802		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (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	F 812		

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F 812	Continued From page 76	F 812		

by:
Based on food storage observations, resident dining observations, dietary staff and nursing staff interview and departmental and administrative document review the facility failed to ensure safe and effective food production operations when 1) foods capable of supporting bacterial growth associated with food borne illness were not monitored for time/temperature control for food safety; 2) Staff handled ready-to-eat (food that is edible without additional preparation) touching with bare hands; and 3) Pans were stored wet.

Findings:

1. Potentially Hazardous Foods (PHF's) are those capable of supporting bacterial growth associated with foodborne illness. PHF's require time/temperature control for food safety during production, storage as well as hot and/or cold holding. Foods classified as PHF's include cooked grains, cooked legumes and protein based foods such as meat. Specifically foods prepared from ingredients at ambient room temperature must be cooled to 41 degrees F or below within 4 hours (Food Code, 2017).

Holding temperatures for food safety specify cold foods should be held at 41 degrees F (Fahrenheit) of below and hot foods at 135 degrees F or greater. Foods held outside of these temperature ranges may promote an environment for bacterial growth (Food Code, 2017).

On 11/13/19 at 1:10 PM, café meal service was reviewed. It was noted there were greater than 3 residents eating the noon meal in the café area. The café service line included a hot holding as

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F 812	Continued From page 77 well as a cold holding area. It was noted in the cold holding area there was a cous cous salad with a temperature of 57 degrees F (Fahrenheit); hummus-45 degrees F; hard boiled eggs-49.5 degrees F. There were also meatballs at 119 degrees F and 131 degrees F respectively in two different areas of the steam pan. In an interview on 11/13/19 at 1:30 PM, Food Service Worker (FSW) 5 stated he prepared the cous cous salad which was made at 9:30 AM on 11/13/19. He also stated no temperature taken post production. At 10:35 was placed in a 4 inch, one-half pan and put in the cafe cold deck. FSW 5 also stated he was responsible for salad preparation in this area of the café based on a weekly menu. Review of menu titled "Good Nutrition Month 2016" indicated on Thursdays tuna salad was a routine item on the cold deck. Review of the café holding temperature log dated 11/13/19 revealed while temperatures were monitored for the hot foods, cold deck temps not taken. In a concurrent interview Foodservice Worker 6 confirmed no cold deck temps taken. Review of the café holding temperatures, revealed the meatballs were recorded with a temperature of 152 degrees F at 1 PM. FSW 6 was unable to explain the discrepancy. Review of facility document titled "LHH Nutrition Services Trayline Temperature Quality Control" indicated facility standards for cold holding was 41 degrees F or below and the hot holding standard was 140 degrees F or above. Review of facility document titled "Laguna Honda Hospital - Food & Nutrition Services HACCP (Hazard Analysis Critical Control Point) Temperature Log for Cooking and Cooling Foods" dated 9/26/16	F 812		

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F 812	Continued From page 78	F 812		

revealed there was no guidance for the necessity to cool foods prepared from ingredients at ambient room temperature, rather was limited to hot foods.

2. According to the 2017 Federal Food Code, staff may not contact exposed ready-to-eat food with bare hands and are to use utensils such as gloves to handle the food.

On 11/12/19 at 11:55 a.m., an observation and concurrent interview with Home Health Aide 1 (HHA 1), showed she sat next to a resident in the "2 PM" dining room while she fed him his lunch which included a croissant. She picked up a croissant with her hands and fed it to the resident. She was not wearing gloves. She repeated this process twice. She stated she washed her hands before feeding the resident so it was okay to touch the croissant with bare hands.

On 11/12/19 at 12:30 p.m., an observation showed Certified Nursing Assistant 1 (CNA 1), touched ready-to-eat food.

In an interview on 11/13/19 at 4:30 p.m., Registered Nurse 1 (RN 1), stated she was responsible for onboarding (orientating new employees) all levels of nursing staff and was also a back-up educator. She stated that when feeding residents, it was okay to touch ready-to-eat foods such as a croissant with bare hands when feeding a resident as long as hands were washed beforehand.

Review of the document titled "Mealtime Competency Checklist for Nursing Staff" dated 10/22/19, showed a question under the category "preparation of meal" phrased "staff uses the

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F 812	Continued From page 79 proper hygienic practices." There were no questions in the competency document regarding hand hygiene or handling ready-to-eat foods when preparing and setting up trays for residents or feeding the residents. Review of the "Mealtime Competency Evaluation for Patient Care Assistant" for RN 1, signed on 9/25/19, did not show that the competency evaluation included how to handle ready-to-eat food. 3. According to the 2017 Federal Food Code, equipment and utensils are to be air dried. On 11/12/19 at 9:40 a.m., an observation and concurrent interviews with Food Service Worker 1 (FSW 1) and the Director of Food Service (DFS), showed 4 pans stacked inside one another that were wet on the inside on a cart located in a food preparation area. FSW 1 stated the pans were used for salad bar foods. The DFS stated the pans should be dried before they were placed on the rack. On 11/12/19 at 9:50 a.m., an observation and concurrent interviews with Cook 1, Cook 2, and the DFS, showed more than 20 half pans were wet and stacked within one another in a food preparation area. Cook 1 stated the pans were used for soups, sauces, and pureed food. Cook 2 removed one wet pan from the stack and poured pureed carrots into it. She stated she was going to put the pan of carrots in the refrigerator to serve later. The DFS stated the pans should be dry.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)	F 814		

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F 814	Continued From page 80 §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility document review, the facility failed to dispose of garbage and refuse properly when recycle bins were dirty and the lids were not closed. This failure had the potential to attract pests and transfer harmful microorganisms to food leading to foodborne illness for a census of 741 residents. (Cross-reference F-925) Findings: Observations and interviews from 11/12/19 to 11/13/19 showed the presence of flies in the kitchen and rat activity around the loading dock area. It was also observed that recycle bins located in the loading dock area were very full so the lids did not close and used food containers were exposed. In addition, the recycle bins in the kitchen and stored outside were dirty on the inside surface with a significant amount of residue. (Cross-reference F-925) Review of the policy and procedure titled "Proper Disposal of Garbage" last revised 8/14, showed the covers of the recycle bins were to be covered at all times and the blue bins were to be cleaned and sanitized when they were emptied.	F 814		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		

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F 880	Continued From page 81 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 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	F 880		

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F 880	Continued From page 82 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 document review, the facility failed to develop, follow or implement policies and procedures to observe infection control practices on six random residents (Resident 173, 326, 418, 436 and 698) and appropriate use of shared instruments or tools when: 1) Hand hygiene were not followed on four out of 5 medication pass observations for Resident 698, Resident 326, Resident 173, and Resident 418; 2) Four out of five medication room refrigerators (1st floor units 1N-A, 1N-B and 6th floor units 6N-A and 6N-B) were found to be unclean with	F 880		

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F 880	Continued From page 83 dark stains and black and white dust residues at the bottom and door corners; 3) Three out of five pill crushers (devices used to crush pills) in the first and sixth floors on the north building were found to be unclean with yellow stains and residues; 4) Shared glucometer (device used to measure sugar level in the blood) was not cleaned per manufacturer guidelines and facility's policy after single resident use (Resident 436.) 5) Outdated Preventive Maintenance for two Nebulizers, items A2985 and A0567 These failures had the potential of exposing patients to infections due to cross contamination. Findings: 1a. During a concurrent interview and medication pass observation on 11/13/2019 at 7:40 a.m., Licensed Nurse 4 (LVN 4) did not use gloves to administer a topical medication patch on Resident 698's skin. LVN-4 stated that he used hand wipes to clean his hand before patient contact and he assumed that was adequate for infection prevention purposes. A review of Resident 698's medical record on 11/13/2019, indicated she had a history of MRSA (MRSA was a bacteria or bug that many antibiotics were not effective against; being colonized with MRSA means one can carry the bug in nose or on the skin but not sick with a MRSA infection.) 1b. During another concurrent interview and	F 880		

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F 880	Continued From page 84 medication pass observation on 11/13/2019 at 08:06 a.m., LVN 4 did not clean hand with antimicrobial pad or gel before putting on gloves to prepare and administer the medications for the Resident 326. LVN 4 realized the missed opportunity and stated that he was focused on making no mistake and was aware of hand sanitization before and after glove use. 1c. During a concurrent interview and medication pass observation of Resident 173 on 11/14/2019 at 8:05 a.m., Licensed Nurse 5 (LVN 5) did not clean hand with antimicrobial hand gel or pad before putting on gloves to administer medication. LVN 5 administered a total of 7 medications including a topical medication patch to Resident 173's knee and neck area. LVN 5 acknowledged the missed opportunity to clean hands before and after glove use. 1d. During a medication pass observation of Resident 418 on 11/14/2019 at 8:26 a.m., Licensed Nurse 6 (LVN-6) prepared the medications and entered Resident 418 room without using gloves. Additionally, LVN-6 did not wash hands or used antimicrobial pad or gel when changing gloves in-between contact to resident's tube feeding areas and administering medications. In an interview with LVN-6 on 11/14/2019 at 8: 52 a.m., she stated that she assumed there was no need to wash hands, use gel or pad with changing gloves when caring for the same resident. LVN-6 assumed, the hand sanitization before and after glove change was only suitable when switching from one resident to the next. In an interview with Registered Nurse Supervisor	F 880		

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F 880	Continued From page 85 8 (RN-8) on 11/14/2019 around 11:00 a.m., she stated that facility's policy required the use of hand gel and hand washing before and after glove use during resident care including medication administration. On 11/15/2019, a review of hospital policy number 72-01 titled "Infection Surveillance Program" last revised on 11/13/2018, indicated "Laguna Honda Hospital ... shall implement an effective process ... to prevent, recognize, and control ... the onset and spread of infection within the facility ..." The policy further indicated, the ICN (Infection Control Nurse) "conducts observation rounds for staff compliance with hand hygiene ... specialized precautions and general infection control standards wherever resident care activities are carried out ..." On 11/15/2019, a review of hospital policy number J1.1 titled "Obtaining, Handling, and Storage of Medications" last revised on May 2019, indicated "The pharmacist or pharmacy extern student may observe the nurse while doses of medication are being prepared and administered ... to ascertain that medications are given ... with acceptable infection control measures employed." 2a. During a concurrent interview and observation, accompanied by Licensed Nurse 3 (LVN-3) and Clinical Nurse Specialist 2 (CNS-2) on 11/12/2019 at 10:30 a.m., medication refrigerators on the first floor of the north building (unit 1N-A, 1N-B) were found to be unclean with black and white stains, spills or residue at the bottom of the refrigerator and on the door linings. In an interview with Nurse Manager 6 (NM-6) and	F 880		

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F 880	Continued From page 86	F 880		

Charge Nurse (RN-9) on 11/14/2019 at 1:14 p.m., they both stated that they were not sure whose responsibility was to keep the medication refrigerator clean. However, they thought it should have been everyone's responsibility to keep the medication storage area, including refrigerator clean and free from spills and contaminations.

2b. During a concurrent interview and observation, accompanied by Nurse Manager 4 (NM-4) on 11/12/2019 at 1:20 p.m., medication refrigerators on the 6th floor of the north building (unit 6N-A and 6N-B) were found to be unclean with black and white stains, spills or residue at the bottom of the refrigerator and on the door linings. NM-4 acknowledged the need to keep the refrigerators clean.

On 11/15/2019, a review of hospital policy number D9 9.0 titled "Maintaining Temperature of Medication ... refrigerators via TEMPTRACK and Cleanliness of the Refrigerators" last revised on January 2015, indicated the purpose of policy as "to store substances that require refrigeration in a hygienic refrigerator environment ..." The nursing policy additionally described how to clean the refrigerator, however, it did not address who was responsible for the function.

3a. During a medication room inspection of the 1st floor nursing unit on the north building (1N-A and 1N-B), accompanied by Charge Nurse 6 (RN-6) on 11/12/2019 at 11:00 a.m., the electrical pill crushers were observed to be unclean with yellow color stains and dust. The manual or non-electrical pill crusher also was observed to have dark color residue and dusts on the corners.

In an interview with RN-6 on 11/12/2019 at 11:23

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F 880	Continued From page 87 a.m., she acknowledged that it was the nursing staff's responsibility to keep the pill crusher clean after each use. She noted they probably needed a deep cleaning to remove the deposits and the stains. 3b. During a concurrent interview and medication room inspection of the 6th floor nursing unit on the North building (6N-A and 6N-B), accompanied by Nurse Manager 4 (NM-4) on 11/12/2019 at 2:10 p.m., the electrical pill crushers were observed to be unclean with yellow color stains and dust. One electric pill crusher was observed to had what appeared to be a light yellow powder in the cup container. NM-4 could not figure out when or who left the apparent crushed medication powder in the pill crusher. Additionally, NM-4 stated that all nurses were responsible to keep the device clean after each use. On 11/15/2019, a review of hospital policy number J1.0 titled "Medication Administrations", last revised on 9/10/2019, referenced "Crushing Medication for Oral Administration" on section D. The policy, however, only addressed the cleaning of the pill cutter but not the pill crusher. 4. During a medication pass observation of Resident 436 on 11/13/2019 at 11:27 a.m., Licensed Nurse 7 (RN-7) was observed checking the blood sugar and then cleaned the glucometer afterward. RN-7 used one packet of Super Sani-Cloth disinfectant pad (facility's approved glucometer cleaning product) and cleaned and disinfected the glucometer's outer body with a contact time (the amount of time it takes for the disinfectant to work) of less than 45 seconds.	F 880		

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F 880	Continued From page 88 A review of the Super Sani-Cloth disinfectant labeling on 11/13/2019 at 12:04 p.m., indicated "Allow treated surface to remain wet for a full Two (2) minutes." In an interview with RN-7 on 11/13/2019 at 12:04 p.m., she acknowledged that she did not allow a full two minutes of contact time for cleaning of the glucometer per manufacture recommendation. Additionally, she was not aware of the 2 minutes' minimum contact time requirement per labeling. In an interview with Nurse Manager 5 (NM-5) on 12/13/2019 at 12:18 p.m., she stated the they needed to do more educational audits and more detailed instructions to help the staff understand their role in infection control and medication use process. On 11/15/2019, a review of hospital policy number G 5.0 titled "Blood Glucose Monitoring", last revised on 5/14/2019, indicated "Proper infection control procedures are followed when using the facility-approved glucometer machine ..." "a. Glucometer machine is cleaned after each use and in-between patient with facility-approved disinfectant wipes for the glucometer." "b. Using gauze, thoroughly dry the glucometer after cleaning and disinfecting. Verify that the meter is dry and there is no solution left on the meter." 5. Nebulizer's Preventive Maintenance outdated for items A2985 and A0567, at the North Mezzanine During the initial tour of unit North Mezzanine (NM) on 11/12/19 at 10:30 AM, escorted by the Nurse Manager (NM 4), while in Room "NM24 B" a nebulizer (A drug delivery device used to	F 880		

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F 880	Continued From page 89 administer medication in the form of a mist inhaled into the lungs. Nebulizers are commonly used for the treatment of asthma and other illnesses), had an inventory sticker identifying it as "A2985", and another sticker label "This device inspected and confirmed patient ready" with two handwritten dates "Inspected 6/18" and "Next inspection due 6/19"....NM 4 stated "It was due for preventive maintenance on June of this year, I don't know what happened....we should not use it....". During the same tour, while at Room NM46 A, another nebulizer with an inventory sticker identifying it as "A0567"with a similar sticker as the previous nebulizer, with two handwritten date of Inspected 4/18" and "Next inspection due 4/19". NM 4 acknowledged the information on the nebulizer and stated "They also missed this one...we need to remove it until it is inspected..." NM 4 explained that "It is Biomed department who does inspection of the nebulizers, usually once a year...Yes, we need to make sure the nebulizers are clean and functioning well..."	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on dietetic services observations, dietary staff interview and departmental document review the facility failed to maintain the physical environment in accordance with standards of practice when 1) two of ten handwashing sinks	F 921		

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LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

(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 921	Continued From page 90 did not maintain temperatures and 2) broken tiles were not repaired. Failure to ensure maintenance of the physical environment may result in staff not completing handwashing in an effective manner and/or may result in unclean kitchen areas providing an area for attraction of pests all of which may result in contamination of resident food. Findings: 1. The standard of practice would be to ensure a handwashing sink is equipped to provide water at a temperature of at least 100 degrees F (Fahrenheit) through a mixing valve or combination faucet. Warm water is more effective than cold water in removing the fatty soils encountered in kitchens. An adequate flow of warm water will cause soap to lather and aid in flushing soil quickly from the hands. Standards for testing the efficacy of handwashing formulations specify a water temperature of 100 to 108 degrees F. An inadequate flow or temperature of water may lead to poor handwashing practices by food employees (Food Code, 2017). During initial tour on 11/12/19 beginning at 8:45 AM, it was noted the water in the handwashing sink located in the dish room was cold. In a follow up observation on 11/13/19 at 10:40 AM it was noted the water temperature of the handwashing sink adjacent to the steam kettles was 122 degrees F (Fahrenheit). In a concurrent interview with Cook 1 stated the water was usually hot. In a concurrent observation the water in the dish room sink was 74 degrees F. It was also noted that it took greater than 3 minutes for the water to reach 100 degrees F.	F 921		

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	555020	A. BUILDING _____ B. WING _____	11/19/2019

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F 921	Continued From page 91 Review of facility policy titled "Hand Wash Sink Stations" dated 8/14 indicated the importance of handwashing to prevent contamination of foods. It also noted the importance of handwashing at properly equipped sinks to ensure employee handwashing compliance. While the policy indicated the importance of handwashing it did not include minimum or maximum water temperature standards. Review of facility document titled "Hand Wash Sink Temperatures and Oasis Sanitizer Testing" for November 2019 indicated all temperatures within acceptable parameters. 2. The standard of practice would be to ensure materials for indoor floors shall be smooth, durable, and easily cleanable for areas where food establishment operations are conducted (Food Code, 2017). During initial tour on 11/12/19 beginning at 8:45 AM, it was noted there were multiple broken floor tiles in front of the steam kettle. In an interview on 11/13/19 at 1:30 PM the Director of Food Services stated broken tiles were a consistent problem as they did not readily hold up in the high traffic areas in the kitchen. Additionally, he stated broken tiles were temporarily fixed by maintenance staff by removing the cracked tile and filling in the area to create a level surface. Review of facility document titled "LHH Kitchen Floor Tile Work Requests for October 2018 through November 2019 failed to note the observed broken tiles.	F 921		
F 925	Maintains Effective Pest Control Program	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 925 SS=F	Continued From page 92 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 facility document review, the facility failed to maintain an effective pest control program when flies were observed in the kitchen and a rat was observed in the loading dock area multiple times. This failure had the potential for pests to transfer harmful microorganisms to food leading to foodborne illness for a census of 741 residents. Findings: An observation in the dishwashing room on 11/12/19 at 11:25 a.m., showed more than 20 small flies on the walls, ceiling, and flying around two large blue recycle bins. The recycle bins were ¼ full with plastic containers that had food residue in them. Also the sides of the bins had a significant amount of thick, dark brown, and black residue. On 11/12/19 at 2:30 p.m., an observation and concurrent interviews with the Senior Food Supervisor (SFS), and the Director of Food Service (DFS), showed over 15 recycle bins outside in the loading dock area. The bins were so full that the lids did not close. There were exposed food containers with food residue inside the bins. The DFS stated a company picks up full bins 6 days a week. A rat, not less than 6 inches long not including the tail, was observed in the loading dock area and went into a hole in the ground. A rat was observed one more time	F 925		

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F 925	Continued From page 93 during the interview. Multiple holes were observed in the area where there was dirt. There were used, empty food containers by some of the holes or slightly inside the holes. The SFS stated the recycle bins were cleaned by food service staff 3 times a week. She stated the bins were taken into the kitchen every day at mealtimes that happened at 7 a.m., 3 p.m., and 5 p.m. Items were scrapped into the bins and then taken out when they were full after mealtime about 3 hours later. The DFS stated the bins that were taken into the kitchen were clean. Observed Food Service Worker 2 (FSW 2), rolling a recycle bin from the loading dock area toward the kitchen. The bin had a significant amount of dark residue on the inside surfaces. There was also a wet substance, used plastic food containers, and dried weeds in the bottom of the bin. FSW 2 confirmed the bins were cleaned 3 days a week on Monday, Wednesday, and Friday, so would not be cleaned that day before taking it into the kitchen. Back inside the kitchen, the DFS confirmed there were flies in the kitchen and dish room area. In addition, between 30 to 40 flies were readily visible on the dish room walls and ceiling, between 5 to10 flies were on the ceiling in the cold production area, and 5 to 10 flies were on the ceiling in the main kitchen area. In an interview on 11/13/19 at 10:15 a.m., the Director of Environmental Services (DES) stated there was a routine pest control service twice a week for the entire hospital and there was noted increased activity of rats since September. Stated if bait did not work to control the rats, the company recommended traps that needed approval from the county. He stated the company set 100 traps last night and caught 11 rats. He stated there was no trapping before	F 925		

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F 925	Continued From page 94 September and traps would not be put out unless there was enough activity. In an interview on 11/14/19 at 9:05 a.m., with the pest control technician (PCT), the pest control company CEO (PCC), and the DES, the PCT stated flies were attracted to areas that were not cleaned well and flies could mechanically transfer organisms. He said the main treatment for flies was to get rid of food debris and accumulation of food debris. He also said he did an inspection of the kitchen every other week and checked kitchen logs for pest activity and went into the kitchen based on the logs. He stated the pest reports for the kitchen stayed in the kitchen and did not go to the DES. When he inspected the kitchen, it was early in the morning before the recycle bins were brought in. He stated he was also the contact person for rodents and he did notice rat activity around the loading dock area. He said the least toxic measures were used but when increased activity was identified then other measures were taken. He stated more activity was noted earlier in the year and trapping started in September. He set the traps again last night. He stated prior to trapping, bait was used. He noticed the rats were not taking the bait because the rats might prefer the food residue in the bins over the bait. Then he stated birth control for rats was used for about a month from August to September but was stopped and that birth control program had to be ongoing for it to be affective. On 11/14/19 at 10 a.m., in an observation and interview with the PCC, the PCC caught a fly in the kitchen using a net and confirmed it was a black eyed fruit fly. The facility provided pest reports from 11/15/18 to	F 925		

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F 925	Continued From page 95 11/14/19. It was noted that there were no reports provided between 4/18/19 and 6/6/19. Review of the reports showed on 4/11/19 the facility reported rat dropping near empty milk carton crates and compost bins and PCT recommended weekly night trappings in the loading dock area. In the report dated 6/6/19 and 6/27/19, the recommendation for rat traps was still in effect. It was noted from the interviews that trapping did not start until 9/19. In the reports from 4/18/19 to 11/14/19 a gap was reported in a sliding door when the sliding door was closed. The sliding door was located at the loading dock, which was the entrance to the kitchen. The recommendation was to fix the gap to prevent rodents entering the kitchen area. The reports also indicated fly activity in the dish washing area. The presence of fruit flies in different areas of the kitchen was consistent in the reports from 11/15/18 to 11/14/19. On the report dated 10/10/19, it was noted that a recommendation was given on 9/22/16 to wash garbage containers with soapy water and filthy garbage containers would attract pests. The facility was not able to provide documentation for facility Environment of Care Rounds in the kitchen since October of 2018.	F 925		

Plan of Correction

F 000

This Plan of Correction is the response by Laguna Honda Hospital and Rehabilitation Center ("LHH" or “facility”) as required by regulation, to the Statement of Deficiencies and Plan of Correction (CMS-2567) issued by the California Department of Public Health on November 19, 2019 and received by the facility on January 9, 2020 as part of the Skilled Nursing Facility Recertification Survey. The submission of this Plan of Correction does not constitute an admission of the deficiencies listed on the Summary Statement of Deficiencies or an admission to any statements, findings, facts, and conclusions that form the basis of the alleged deficiencies.

Plan of Correction

F552
§ 483.10 Right to be Informed/Make Treatment Decisions
(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:

(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.
(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.
(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to ensure psychotropic medication (a medication capable of affecting the mind, emotions, and behavior) was administered with consent of Resident 992 (Res 992) or its authorized agent per facility's policy.

Corrective Action:

1. **Physicians received instruction on completion of consent form for psychotropic medication orders prior to administering psychotropic medication to any resident. A memo was distributed to all medical staff.**
   Responsible Person:
   Chief of Staff.
   Completion Date:
   December 19, 2019 and ongoing.

2. **License nurses received an in-service on not providing psychotropic medication without a completed consent form in the residents' medical record.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   December 19, 2019 and ongoing.

3. **A review of all residents' medical charts was conducted to ensure those with psychotropic medication orders have a completed consent form. The Pharmacist will review the Consent for Psychoactive Medication monthly during the Drug Regimen Review (DRR) for any inconsistencies with LHH policy and procedure. The Pharmacist will report findings to the Chief Medical Officer for follow-up.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   Compliance shall be reported monthly to Pharmacy and Therapeutics Committee (P&T), quarterly to Performance Improvement and Patient Safety Committee (PIPS) and the Medical Executive Committee (MEC), these committees shall report overall compliance to Joint Conference Committee (JCC), the Governing Body until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

4. **A memo was distributed to medical staff indicating that licensed nurses are to not administer first does of psychotropic medications without a documented consent and to contact the prescribing provider to then complete the appropriate protocol to obtain a completed consent form.**
   Responsible Person:
   Chief Quality Officer.
   Completion Date:
   December 19, 2019 and ongoing.

Plan of Correction

F600

§ 483.12 Freedom from Abuse, Neglect, and Exploitation

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

(a) The facility must-

(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to ensure one of 54 residents was free from verbal abuse, (Resident 708), when one staff (RN 16) told a resident (Resident 708) during care, "Don't ever interrupt my dinner."

Immediate Corrective Actions:

1. **Nursing Supervisor and Nurse Manager promptly initiated an investigation upon receiving report of the alleged abuse from CDPH surveyor. Abuse protocol was implemented.**
2. **RN 16 was removed from resident care area on 11/18/19.**
3. **RN 16 received in-service on Abuse Prevention and Customer Service on 11/19/19.**
4. **The Unit physician was notified of the allegation of abuse and a wellness assessment was conducted.**
5. **The resident was monitored for 72-hours by the Resident Care Team (RCT) for any change in mood, behavior and activities. The resident was provided with psychosocial support by the RCT and there have been no noted changes in mood or activities.**
6. **Information was added to the report sheet for hand-off - message to float staff regarding how to communicate effectively with resident.**
7. **A nursing note was added in Epic to make staff aware of effective communication with resident.**
8. **A guide was posted in the room, which pertains to staff properly introducing self, communicating with resident, and ensuring needs are met prior to leaving the room.**

   Responsible Person:

   Unit Nurse Manager.

   Completion Date:

   November 21, 2019.

Corrective Actions:

9. **To sustain the detection of other residents having the potential to have been affected by the same deficient practice, Nurse Managers and other members of the resident care team will continue resident check-ins with each resident on every neighborhood on a weekly basis. The tool includes assessment methods for residents unable to communicate. The questions and frequency of the check-in will be adjusted based on data outcomes. Any issues identified during resident interviews are immediately escalated according to the abuse protocol.**

   Responsible Person:

   Chief Nursing Officer.

   Completion Date:

   December 9, 2019 and ongoing.

   Monitoring:

   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to

Plan of Correction

NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

F656
§ 483.21 Develop/Implement Comprehensive Care Plan
(b) Comprehensive Care Plans
(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.1 0(c)(2) and
(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 §483.1 0(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.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to develop care plans for resident specific care concerns for four of 35 sampled residents (Residents 71 Resident, 196, Resident 630, and Resident 685).

Immediate Corrective Actions:

1. **The care plan for Resident 71 was updated to reflect a communication care plan and diabetes care plan with measurable objectives for blood glucose levels.**
2. **The care plan for Resident 196 was updated to reflect management of prostate enlargement.**
3. **The care plan for Resident 630 and Resident 685 was updated to reflect management of indwelling urinary catheters.**

Responsible Person:
Chief Nursing Officer.
Completion Date:
December 3, 2019 and ongoing.

Corrective Actions:

4. **A memo was distributed to all medical staff regarding the need for clear documentation addressing residents' current diagnosis and problem list.**

Responsible Person:
Chief of Staff.

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Completion Date:

December 19, 2019 and ongoing.

5. **The facility initiated a review of the current condition of resident care planning process on 12/11/19. The review (A3) identified gaps within the facility's current processes and new electronic health record. Countermeasures identified to enhance the facility's resident centered care planning; a) care plan content review and revision, b) resident care team education, c) standardization of resident care conference process, d) EHR care plan optimization and system functionality enhancement.**

   Responsible Person:

   Nurse Program Director.

   Completion Date:

   December 19, 2019 and ongoing.

   Monitoring:

   The Nurse Program Director shall report updates to Nursing Quality Improvement Council (NQIC), PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body. This monitoring will continue until three consecutive months of compliance with the goals set in the A3 have been achieved.

6. **Licensed nurses will review residents' orders and evaluate plan of care during the weekly and/or monthly summary. Care plans will be reviewed by the Resident Care Team during quarterly meetings and special reviews to ensure there is a person-centered plan of care.**

   Responsible Person:

   Chief Nursing Officer.

   Completion Date:

   Ongoing

   Monitoring:

   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

7. **Licensed nurses received an in-service on care planning procedures in Epic and blood glucose panic levels.**

   Responsible Person:

   Nurse Educator.

   Completion Date:

   December 19, 2019 and ongoing.

8. **Nursing policy and procedure NPP G 5.0 Blood Glucose Monitoring was revised to include panic levels.**

   Responsible Person:

   Clinical Nurse Specialist.

   Completion Date:

   December 19, 2019 and ongoing.

Plan of Correction

F658
§483.21 Services Provided Meet Professional Standards
(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to ensure two out of four random residents (Resident 698 and Resident 173) were administered topical medication pads up to safety standards.

Immediate Corrective Action:

1. **The topical medication pads for Resident 698 and Resident 173 were labeled with the date and time of administration to meet safety standards.**
   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   November 18, 2019.

Corrective Actions:

2. **Nursing policy and procedure NPP J 1.0 Medication Administration was revised to include the safety standard of putting the date and time on all topical patches upon application on the resident.**
   Responsible Person:
   Clinical Nurse Specialist.
   Completion Date:
   December 19, 2019 and ongoing.

3. **Licensed nurses received an in-service on the safety standard when administered topical patches to residents.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   December 19, 2019 and ongoing.

4. **The Nursing Department implemented a random audit that includes medication administration for all 13 neighborhoods across all 3 shifts. Four medication passes are audited per unit/per day. The medication administration audit tool was revised to include the observation of labeling topical patches with date and time prior to application when administered to the resident.**
   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring**:**
   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to Nursing Quality Improvement Council (NQIC), PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Plan of Correction

F676
§ 483.24 Activities Daily Living (ADLs)/Maintain Abilities
(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

(b) Activities of daily living.
The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

(1) Hygiene -bathing, dressing, grooming, and oral care,
(2) Mobility-transfer and ambulation, including walking,
(3) Elimination-toileting,
(4) Dining-eating, including meals and snacks,
(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.

CDPH concluded that this **REQUIREMENT** was not met when the facility did not provide appropriate treatment and services for one of 35 sampled residents, Resident 547, when needed orthotics shoes were not made available.

Immediate Corrective Actions:

1. **Resident 547's care plan was updated to include orthotic follow up and shoe fitting.**
   Responsible Person:
   Unit Nurse Manager.
   Completion Date:
   November 18, 2019.

2. **The social worker presented 12 different options to Resident 547 for shoes to provide orthotic lift for resident.**
   Responsible Person:
   Medical Social Worker.
   Completion Date:
   December 2, 2019.

3. **The physician assessed Resident 547 as stable for her right food contracture and noted follow up for orthotic shoes.**
   Responsible Person:
   Chief Medical Officer.
   Completion Date:
   December 4, 2019.

Plan of Correction

4. **The facility procured the shoes and provided to UCSF Orthotics for fabrication.**
   Responsible Person:
   Medical Social Worker.
   Completion Date:
   December 12, 2019.

Corrective Action:

5. **A standard work to identify residents with orthotic non-covered benefit recommendations was developed. The list of residents will be reviewed monthly to identify alternative measures or funding options. Referrals will be made as appropriate for alternative funding as needed.**
   Responsible Person:
   Medical Social Worker.
   Completion Date:
   December 12, 2019.
   Monitoring:
   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Plan of Correction

F700
§ 483.25
(n) Bedrails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.
(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.
(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to obtain informed consents, perform an entrapment risk assessments and develop a care plan before using bed rails (are adjustable metal or rigid plastic bars that attach to the bed) for two of 39 residents (Resident 382 and Resident 465).

Immediate Corrective Action:

1. **A comprehensive chart review was conducted for Resident 465 and the medical record was updated to reflect a bedrail plan of care, signed consent, and bedrail risk assessment.**
   Responsible Person:
   Unit Nurse Manager.
   Completion Date:
   November 22, 2019.

Corrective Actions:

2. **A comprehensive chart review was conducted for Resident 382 and the medical record was updated to reflect a bedrail plan of care, signed consent, and bedrail risk assessment.**
   Responsible Person:
   Unit Nurse Manager.
   Completion Date:
   December 9, 2019.

3. **The facility created and extracted a report from the EHR of residents with active physician order for bedrail use. The nursing leadership utilized the data to ensure the following information are present for all residents on the report; 1) order continues to be active, 2) complete quarterly assessment, 3) complete bedrail care plan, and 4) Active consent.**
   Responsible Person:
   Nursing Program Director.
   Completion Date:
   December 6, 2019.

Plan of Correction

4. **As the current EHR is new to LHH, Epic message boards (Bedrail Care Plan and Non-Restrictive and Restraint) were released to the nursing leadership and staff as re-education and reference. Review of the message boards with charge nurses were conducted.**
   Responsible Person:
   Nursing Program Director.
   Completion Date:
   December 6, 2019.

5. **A monthly audit of 10 residents in each neighborhood will be conducted if in need of bedrail use. The QA will review the following; a) Active physician order, b) Individualized Care Plan, c) Quarterly Bedrail Assessment, d) Review of bedrail use on a Resident Care Team quarterly note, e) Physical inspection of each bedrails (4/4) of resident's bed, and f) Resident Consent.**
   Responsible Person:
   Chief Quality Officer.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Plan of Correction

F744
§ 483.40 Treatment/Service for Dementia
(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to develop and implement a person-centered care plan for 2 of 35 sampled residents (Resident 68 and 71) and 2 random residents (Residents 256 and 327) with dementia (disease of the brain causing symptoms such as loss of memory, judgement, ability to communicate and solve problems, and interference with daily functioning).

Immediate Corrective Action:

1. **Comprehensive chart review was completed for Resident 68, 71, 256, and 327. Their medical records were updated to reflect a person-centered dementia care plan.**
   Responsible Person:
   Unit Nurse Manager.
   Completion Date:
   November 22, 2019.

Corrective Actions:

2. **The facility initiated a reeducation of nursing staff of dementia care for residents. The training focuses on staff providing person-centered care for residents.**
   Responsible Person:
   Clinical Nurse Specialist.
   Completion Date:
   December 16, 2019 and ongoing.
   Monitoring:
   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Plan of Correction

F756
§ 483.45 Drug Regimen Review, Report Irregular, Act On
(c) Drug Regimen Review

(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.
(2) This review must include a review of the resident's medical chart.
(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph.
(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

(d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to identify irregularities and make recommendations to the facility for two of 35 sampled residents (Residents 68 and 735) and one random resident (Resident 373).

Immediate Corrective Actions:

1. **Resident 68 risperidone was discontinued.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   November 14, 2019.

2. **Pharmacy and attending provider discussed the appropriateness for the benzocaine spray for Resident 373. The provider added a progress note to reflect the circumstances that lead to benefit outweighing the risk of methemoglobinemia for this case.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   November 19, 2019.

Plan of Correction

3. **Resident 735 risperidone was tapered on 11/14/19 and indication was changed. Provider provided explicit documentation regarding why alternatives are not used over antipsychotic and specific GDR plan on 12/03/2019.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 3, 2019.

Corrective Actions:

4. **Pharmacy has developed standard work for evaluation and documentation of non-formulary requests. Non-formulary requests will be reported out to the P&T Committee with evaluation of each request in accordance with the standard work.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 3, 2019.
   Monitoring:
   Compliance shall be reported to P&T, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body. Compliance will be monitored until three consecutive months of 95% compliance or greater has been achieved.

5. **A report was pulled to review the presence of and appropriate indication for all antipsychotic orders. Providers were contacted to add indication for any orders that contained target symptom as indication.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 19, 2019.

6. **An extended review of all patients receiving antipsychotic for dementia related behavioral disturbance. DRR submitted to request explicit documentation of why nonpharmacological interventions and alternative medications are not appropriate and for a specific GDR plan.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 19, 2019.
   Monitoring:
   DRR response related to psychotropics will be monitored and reported monthly to the P&T Committee. Compliance shall be reported to PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body. Compliance will be monitored until three consecutive months of 95% compliance or greater has been achieved.

Plan of Correction

F757
§483.45 Drug Regimen is Free from Unnecessary Drugs
(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-

(1) In excessive dose (including duplicate drug therapy); or
(2) For excessive duration; or
(3) Without adequate monitoring; or
(4) Without adequate indications for its use; or
(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to ensure two of 35 sampled residents (Residents 531 and 735) and one random resident (Resident 373) were free from unnecessary medications.

Immediate Corrective Action:

1. **Pharmacy and attending provider discussed the appropriateness for the benzocaine spray for Resident 373. The provider added a progress note to reflect the circumstances that lead to benefit outweighing the risk of methemoglobinemia for this case.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   November 19, 2019.

2. **The medical record for Resident 531 was updated to include hold parameters for laxative medication in the administration instructions.**
   Responsible Person:
   Chief Medical Officer.
   Completion Date:
   December 3, 2019

3. **A care plan was developed for monitoring of side effects of anticoagulant for Resident 735. TSH level was obtained. And weekly cardiovascular monitoring was initiated.**
   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   November 15, 2019

Plan of Correction

Corrective Actions:

4. **List of residents on Senna was reviewed to identify order without hold parameters. Hold for loose stool was added to order without hold parameters.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 19, 2019.
   Monitoring:
   Compliance will be monitored and reported monthly to the P&T Committee until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

5. **Pharmacy has developed standard work for evaluation and documentation of non-formulary requests.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 3, 2019.
   Monitoring:
   Non-formulary requests will be reported out to the Pharmacy and Therapeutics (P&T) Committee with evaluation of each request in accordance with the standard work. Compliance shall be reported to PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body. Compliance will be monitored until three consecutive months of 95% compliance or greater has been achieved.

6. **List of residents with anticoagulants pulled and care plans reviewed to assure monitoring for signs and symptoms of bleeding.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 19, 2019.
   Monitoring:
   Compliance will be monitored and reported monthly to the P&T Committee until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

7. **Physicians received instruction to add parameters for medication for each resident as necessary.**
   Responsible Person:
   Chief of Staff.
   Completion Date:
   December 19, 2019 and ongoing.

Plan of Correction

8. **Nursing staff received an in-service to complete appropriate assessments of residents for medications parameters and routine monitoring of cardiovascular medications.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   December 19, 2019 and ongoing.

9. **The facility initiated a review of the current condition of resident care planning process on 12/11/19. The review (A3) identified gaps within the facility's current processes and new electronic health record. Countermeasures identified to enhance the facility's resident centered care planning; a) care plan content review and revision, b) resident care team education, c) standardization of resident care conference process, d) EHR care plan optimization and system functionality enhancement.**
   Responsible Person:
   Nurse Program Director.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Nurse Program Director shall report updates to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body. This monitoring will continue until three consecutive months of compliance with the goals set in the A3 have been achieved.

10. **Licensed nurses will review residents' orders and evaluate plan of care during the weekly and/or monthly summary. Care plans will be reviewed by the Resident Care Team during quarterly meetings and special reviews to ensure there is a person-centered plan of care.**
    Responsible Person:
    Chief Nursing Officer.
    Completion Date:
    Ongoing
    Monitoring:
    The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

11. **Nursing policy and procedure NPP J1.0 was revised to reflect medication parameters.**
    Responsible Person:
    Clinical Nurse Specialist.
    Completion Date:
    December 19, 2019 and ongoing

Plan of Correction

F758
§ 483.45 Free from Unnecessary Psychotropic Meds/PRN Use
(c) Psychotropic Drugs.

(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;
(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and
(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in
(5) If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.
PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to ensure four of 35 sampled residents (Residents 68, 71, 531, and 735) were free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behavior).

Immediate Corrective Actions:

1. **Resident 68 risperidone was discontinued. Behavioral monitoring initiated.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   November 14, 2019.

2. **Resident 71 risperidone was discontinued. Behavioral monitoring initiated.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   November 15, 2019.

3. **Removal of bipolar disorder was completed for Resident 531 and the addition of the appropriate diagnosis of dementia with disturbance disorder.**
   Responsible Person:
   Chief Medical Officer.
   Completion Date:
   December 3, 2019

Plan of Correction

4. **Resident 735 risperidone was tapered on 11/14/19 and indication was changed. Provider provided explicit documentation regarding why alternatives are not used over antipsychotic and specific GDR plan on 12/03/2019.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 3, 2019.

Corrective Actions:

5. **A report was pulled to review the presence of and appropriate indication for all antipsychotic orders. Providers were contacted to add indication for any orders that contained target symptom as indication.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 19, 2019.

6. **An extended review of all patients receiving antipsychotic for dementia related behavioral disturbance. DRR submitted to request explicit documentation of why nonpharmacological interventions and alternative medications are not appropriate and for a specific GDR plan.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 19, 2019.
   Monitoring:
   DRR response related to psychotropics will be monitored and reported monthly to the P&T Committee. Compliance shall be reported to PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body. Compliance will be monitored until three consecutive months of 95% compliance or greater has been achieved.

7. **The facility initiated a review of the current condition of resident care planning process on 12/11/19. The review (A3) identified gaps within the facility's current processes and new electronic health record. Countermeasures identified to enhance the facility's resident centered care planning; a) care plan content review and revision, b) resident care team education, c) standardization of resident care conference process, d) EHR care plan optimization and system functionality enhancement.**
   Responsible Person:
   Nurse Program Director.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Nurse Program Director shall report updates to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body. This monitoring will continue until three consecutive months of compliance with the goals set in the A3 have been achieved.

Plan of Correction

8. **Licensed nurses will review residents' orders and evaluate plan of care during the weekly and/or monthly summary. Care plans will be reviewed by the Resident Care Team during quarterly meetings and special reviews to ensure there is a person-centered plan of care.**
   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

9. **Physicians received instruction to review diagnosis list prior to writing an indication.**
   Responsible Person:
   Chief of Staff.
   Completion Date:
   December 19, 2019 and ongoing.

Plan of Correction

F759
§ 483.45 Free of Medication Error Rates 5 Percent or More
(f) Medication Errors.

(1) Medication error rates are not 5 percent or greater.

CDPH concluded that this **REQUIREMENT** was not met when the facility had a 5.08% error rate when three medication errors out of 59 opportunities were observed during a medication pass

Corrective Actions:

1. **The Nursing Department implemented a random audit that includes medication administration for all 13 neighborhoods across all 3 shifts. Four medication passes are audited per unit/per day. The medication administration audit tool includes the review of proper medication administration per facility policy and MAR.**

   Responsible Person:

   Chief Nursing Officer.

   Completion Date:

   December 19, 2019 and ongoing.

   Monitoring**:**

   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

2. **Licensed nurses received an in-service regarding proper administration of medications through an enteral tube, specifically administering meds separately.**

   Responsible Person:

   Chief Nursing Officer.

   Completion Date:

   December 19, 2019 and ongoing.

Plan of Correction

F761
§ 483.45 Label/Store Drugs and Biologicals
(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.
(h) Storage of Drugs and Biologicals

(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.
(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 I package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to ensure acceptable labeling, storage requirements and removal of expired medications for 9 random residents (Residents 133, 137, 296, 543, 225, 171, 409, 133 and 42).

Immediate Corrective Action:

1. **Proper labeling with patient name and expiration date was placed on medications for Residents 42, 225, 296, 543 during the survey and any non-patient specific medications as appropriate.**
2. **Expired medications for Residents 133, 137, 171, 409 and any non-patient specific medications were removed from active storage area and discarded by Pharmacy during the survey.**
3. **Medication for Resident 225 was placed in appropriate storage temperature per manufacturer instruction during the survey.**

   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   November 19, 2019.

4. **Pharmacy conducted a sweep of med storage areas to add appropriate expiration to each medication container. Pharmacy discussed with all staff the change in label that requires the manual addition of expiration date to label.**

   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 3, 2019.

Plan of Correction

Corrective Actions:

5. **List of items requiring addition of expiration dates developed and posted at pharmacy fill stations.**
   Responsible Person:
   Director of Pharmacy.
   Completion Date:
   December 5, 2019.
   Monitoring:
   Pharmacy staff will be assigned to audit 10 items weekly before leaving the pharmacy. Compliance will be reported to P&T Committee until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

6. **An audit will be completed of the medication cart and medication room after each shift by the Licensed Nurse utilizing a checklist which includes checking for proper labeling of medications and removal of expired medications. A 5S audit of the medication cart and medication room will include checking that medications have been labeled properly and expired medications have been removed by the Unit Nurse Manager.**
   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   December 19, 2019 and ongoing.

7. **Nursing staff will conduct environmental rounds weekly to observe compliance with proper labeling of medication, removal of expired medications, and completion of 5-minute 5s of the medication carts and medication rooms.**
   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Plan of Correction

F802
§ 483.60 Sufficient Dietary Support Personnel
(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).

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

(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21 (b)(2)(ii).

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to ensure the competency of two kitchen staff when they did not demonstrate proper procedures for testing sanitizer strength according to manufacturer's directions. This failure had the potential for the sanitizer to be at an improper strength for sanitizing food contact surface areas leading to food borne illness for a census of 741 residents.

Immediate Corrective Action:

1. **An immediate corrective action was taken to provide the two staff members with immediate in-service on how to test quaternary solution appropriately.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   November 18, 2019

Corrective Action:

2. **An in-service was conduct for all Food Services staff on Oasis 146 Quaternary Sanitizer testing. Additionally, staff were randomly identified and quizzed on the quaternary sanitizer testing procedure.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   December 16, 2019
   Monitoring:
   An audit tool was developed to monitor Quaternary Sanitizer testing of Oasis 146. The Director of Food Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Plan of Correction

F812
§ 483.60 Food Procurement/Store/Prepare/Serve-Sanitary
(i) Food safety requirements.
The facility must -

(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.

(2) Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to ensure safe and effective food production operations when 1) foods capable of supporting bacterial growth associated with food borne illness were not monitored for time/temperature control for food safety; 2) Staff handled ready-to-eat (food that is edible without additional preparation) touching with bare hands; and 3) Pans were stored wet.

Immediate Corrective Action:

1. **Immediate corrective action was taken to properly wash and airdry the identified wet pans. All other pans were then checked for dryness and cleanliness**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   November 18, 2019.

Corrective Actions:

2. **Food Service cooks have been instructed and in-serviced on measuring final cooking temperatures of food items according to minimal internal cooking temperatures, per Federal Food Code 2017. Final cooking temperatures are to be recorded on the "Temperature/Taste Testing Log" and tested for flavor, texture, and appearance.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Chef Production Manager is responsible for monitoring daily compliance through observations that final cooking temperatures are checked and recorded on the Temperature/Taste Testing Log per department procedures; temperature readings are reviewed for correctness, and deviations from departmental procedures are reported during the weekly Food Services management meeting. Compliance will be reported weekly during the Food Services Management meeting, and quarterly to PIPS and MEC until three consecutive months of 95% compliance or greater has been achieved. These committees shall report overall compliance to the JCC, the Governing Body.

Plan of Correction

3. **Food Services policy and procedure 1.89 Quality Assurance: Tray Service Line Temperatures has been updated to include guidelines on the necessity to cool foods prepared from the ingredients at ambient room temperatures.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   December 19, 2019 and ongoing.

4. **The Nursing staff orientation and meal competency tool has been revised to address staff may not contact exposed ready-to-eat food with bare hands and are to use utensils such as gloves to handle the food.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   December 19, 2019 and ongoing.

5. **All Nursing staff received an in-service on facility standard that exposed ready-to-eat food may not be handled with bare hands and staff are to use utensils such as gloves to handle the food.**
   Responsible Person:
   Nurse Educator.
   Completion Date:
   December 19, 2019 and ongoing.

6. **Food Services staff were provided an in-service on Food Services Policy and Procedure 1.677 Manual Ware Washing to ensure staff are aware of the proper method to air-dry pots and pans.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   December 12, 2019 and ongoing.
   Monitoring:
   A management tool was developed to check pans daily by the Food Services Supervisor or Manager on duty. The Director of Food Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Plan of Correction

F814
§483.60 Dispose Garbage and Refuse Properly
(i)(4) Dispose of garbage and refuse properly.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to dispose of garbage and refuse properly when recycle bins were dirty and the lids were not closed. This failure had the potential to attract pests and transfer harmful microorganisms to food leading to food borne illness for a census of 7 41 residents. (Cross-reference F-925)

Immediate Corrective Action:

1. **An immediate corrective action was taken to remove all soiled Recology compost and waste cart from the Food Services department and replaced with 40-gallon bins.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   November 18, 2019.

2. **An immediate corrective action was taken to contact the Pest Company to assess the situation of fruit flies in the Food Services department.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   November 12, 2019.

Corrective Actions:

3. **All compost, recycling, and waste bins were checked inside and outside for cleanliness and sanitation. An audit tool was established to monitor cleaning/sanitizing of bins.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   December 11, 2019 and ongoing.
   Monitoring:
   The Director of Food Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

4. **An in-service was conducted to inform Food Services staff on new 40 gallon bins and daily cleaning/sanitizing process.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   December 11, 2019.

Plan of Correction

5. **Drain pipes were cleaned and treated to prevent fruit flies.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   November 14, 2019 and ongoing.

6. **Food Services staff were provided an in-service on the proper cleaning of floor drains. An audit tool was created to monitor cleanliness of floor drains.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   November 14, 2019.
   Monitoring:
   The Director of Food Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

7. **To eradicate the loading dock area of rodent activity, the placement of traps will be conducted three times a week for the month of November. Thereafter, the placement of traps will be conducted twice a week.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Director of Food Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

8. **Environmental Services staff will conduct inspection of treatment of the burrows twice a week. Staff will service the contrapest stations (rodent birth control).**
   Responsible Person:
   Director of Environmental Services.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Director of Environmental Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Plan of Correction

9. **Environmental Services staff will conduct inspection of sewer pipes twice a week including the opening of manholes and applying rodenticide to sewer pipe for monitoring and control of rodent activity.**

   Responsible Person:

   Director of Environmental Services.

   Completion Date:

   December 19, 2019 and ongoing.

   Monitoring:

   The Director of Environmental Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

10. **Environmental Services supervisors will assign daily cleaning of affected areas to preventative rodent and pest activity.**

    Responsible Person:

    Director of Environmental Services.

    Completion Date:

    December 19, 2019 and ongoing.

    Monitoring:

    The Director of Environmental Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

Plan of Correction

F880
§ 483.80 Infection Prevention & 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.
(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:

(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 (e) and following accepted national standards;

(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 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.

(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.
(e) **Linens.**
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.
(f) **Annual review.**
The facility will conduct an annual review of its IPCP and update their program, as necessary.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to develop, follow or implement policies and procedures to observe infection control practices on six random residents (Resident 173, 326, 418, 436 and 698) and appropriate use of shared instruments or tools.

Immediate Corrective Actions:

1. **Medication room refrigerators were thoroughly cleaned by facility staff.**
   Responsible Person:
   Director of Environmental Services.
   Completion Date:
   November 19, 2019.

2. **Identified pill crushers on the first and sixth floors on the north building were thoroughly cleaned.**
   Responsible Person:
   Unit Nurse Manager.
   Completion Date:
   November 18, 2019.

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3. **Preventive maintenance was completed for Nebulizers, items A2985 and A0567.**
   Responsible Person:
   Manager of Central Processing Department.
   Completion Date:
   December 19, 2019.

Corrective Actions:

4. **Health Care Workers must practice hand hygiene before and after direct resident contact. The frequency of Infection Control Nurse rounding will be increased to quarterly which will include hand hygiene observations. Medication pass observations will include monitoring of compliance with hand hygiene protocol.**
   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

5. **The Emergency Checklist and Nursing policy and procedure NPP D9 9.0 Maintaining Temperature of Medication and Nourishment Refrigerators via Temptrak & Cleanliness of Refrigerators was revised to include regular cleaning of medication room refrigerators by AM shift licensed nurse(s).**
   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

6. **Nursing policy and procedure NPP J1.0 Medication Administration was revised to including cleaning of pill crushers with alcohol wipes after medication pass.**
   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

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7. **An audit will be completed of the medication cart and medication room after each shift by the Licensed Nurse utilizing a checklist which includes checking the cleanliness of the medication room refrigerator and pill crushers. A 5S audit of the medication cart and medication room will include checking the cleanliness of the medication room refrigerator and pill crushers by the Unit Nurse Manager.**
   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   December 19, 2019 and ongoing.

8. **Nursing staff will conduct environmental rounds weekly to observe compliance with cleanliness of medication room refrigerators, glucometer, and pill crushers; proper labeling and maintenance of nebulizers; and completion of 5-minute 5s of the medication carts and medication rooms.**
   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Nurse Program Director will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to NQIC, PIPS, and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

9. **Nursing staff will conduct monthly rounds on bedside equipment such as nebulizer machines to ensure that the preventive maintenance date is current. If the equipment's preventive maintenance is outdated, nursing will send the equipment to Central Supply Department for preventive maintenance.**
   Responsible Person:
   Chief Nursing Officer.
   Completion Date:
   December 19, 2019 and ongoing.

Plan of Correction

F921
§483.90 Safe/Functional/Sanitary/Comfortable Environment
(i) Other Environmental Conditions. The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain the physical environment in accordance with standards of practice when 1) two of ten handwashing sinks did not maintain temperatures and 2) broken tiles were not repaired. Failure to ensure maintenance of the physical environment may result in staff not completing handwashing in an effective manner and/or may result in unclean kitchen areas providing an area for attraction of pests all of which may result in contamination of resident food.

Immediate Corrective Actions:

1. **The Food Services Department submitted work order #109933 for hand washing sink #10 for adequate water flow on 11/16/19. Facility Services completed and work order request.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   November 19, 2019.

2. **The Food Services Department submitted work order #110364 for hand washing sink #2, 3, 4, 6, and 7 for domestic hot water temperature on 11/26/19. The domestic hot water supply temperature has been adjusted to deliver hot water between 105 to 120 degrees Fahrenheit.**
   Responsible Person:
   Director of Food Services
   Completion Date:
   December 16, 2019.

Corrective Actions:

3. **The Food Services staff check and record temperatures for handwashing sinks twice a day, seven days a week to ensure domestic hot water supply temperature is between 105 to 120 degrees Fahrenheit.**
   Responsible Person:
   Director of Food Services
   Completion Date:
   December 16, 2019 and ongoing.
   Monitoring:
   Director of Food Services shall monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

4. **The broken tiles were repaired. A capital project to replace the entire kitchen floor is in the planning phase for FY20-21.**
   Responsible Person:
   Director of Facility Services
   Completion Date:
   Ongoing.

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F925
§483.90 Maintains Effective Pest Control Program
(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.

CDPH concluded that this **REQUIREMENT** was not met when the facility failed to maintain an effective pest control program when flies were observed in the kitchen and a rat was observed in the loading dock area multiple times. This failure had the potential for pests to transfer harmful microorganisms to food leading to foodborne illness for a census of 7 41 residents.

Immediate Corrective Action:

1. **An immediate corrective action was taken to contact the Pest Company to assess the situation of fruit flies in the Food Services department.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   November 12, 2019.

2. **An immediate corrective action was taken to remove all soiled Recology compost and waste cart from the Food Services department and replaced with 40-gallon bins.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   November 18, 2019.

Corrective Actions:

3. **All compost, recycling, and waste bins were checked inside and outside for cleanliness and sanitation. An audit tool was established to monitor cleaning/sanitizing of bins.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   December 11, 2019 and ongoing
   Monitoring:
   The Director of Food Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

4. **An in-service was conducted to inform Food Services staff on new 40 gallon bins and daily cleaning/sanitizing process.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   December 11, 2019.

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5. **Drain pipes were cleaned and treated to prevent fruit flies.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   November 14, 2019 and ongoing.

6. **Food Services staff were provided an in-service on the proper cleaning of floor drains. An audit tool was created to monitor cleanliness of floor drains.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   November 14, 2019.
   Monitoring:
   The Director of Food Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

7. **To eradicate the loading dock area of rodent activity, the placement of traps will be conducted three times a week for the month of November. Thereafter, the placement of traps will be conducted twice a week.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Director of Food Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

8. **The monthly kitchen rounds resumed with the Infection Control Nurse and Food and Nutrition Services leadership.**
   Responsible Person:
   Director of Food Services.
   Completion Date:
   December 19, 2019 and ongoing.
   Monitoring:
   The Director of Fool Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

9. **Environmental Services staff will conduct inspection of treatment of the burrows twice a week. Staff will service the contrapest stations (rodent birth control).**
   Responsible Person:
   Director of Environmental Services.
   Completion Date:

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December 19, 2019 and ongoing.

Monitoring:

The Director of Environmental Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

10. **Environmental Services staff will conduct inspection of sewer pipes twice a week including the opening of manholes and applying rodenticide to sewer pipe for monitoring and control of rodent activity.**

Responsible Person:

Director of Environmental Services.

Completion Date:

December 19, 2019 and ongoing.

Monitoring:

The Director of Environmental Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.

11. **Environmental Services supervisors will assign daily cleaning of affected areas to preventative rodent and pest activity.**

Responsible Person:

Director of Environmental Services.

Completion Date:

December 19, 2019 and ongoing.

Monitoring:

The Director of Environmental Services will monitor compliance monthly until three consecutive months of 95% compliance or greater has been achieved. Compliance shall be reported to PIPS and MEC, these committees shall report overall compliance to the JCC, the Governing Body.