

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

PRINTED: 07/22/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>G</b> <b>07/12/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAGUNA HONDA HOSPITAL &amp; REHABILITATION CTR D/P SNF</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116</b>	
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following reflects the findings of the California Department of Public Health during an Abbreviated Standard Survey.</p> <p>The inspection was limited to the specific incidents investigated and does not represent the findings of a full inspection of the facility.</p> <p>For Facility Reported Incidents: CA00623517 regarding Resident Abuse/Patient/Client, Employee to Resident; CA00639036 regarding Resident Abuse/Patient/Client, Employee to Resident; CA00639047 regarding Resident/Patient/Client Abuse/Employee to Resident CA00639051 regarding Resident/Patient/Client Abuse CA00639848 regarding Resident/Patient/Client Neglect CA00639918 regarding Quality of Care/Treatment CA00639866 regarding Accidents CA00640598 regarding Pharmaceutical Services CA00621775 regarding Quality of Care Treatment CA00638524 regarding Pharmaceutical Services / Quality of Care Treatment CA00621433 regarding Quality of Care Treatment</p> <p>The Department identified violations of Federal regulations.</p> <p>Representing the California Department of Public Health:  33819, Health Facilities Evaluator Nurse.</p>	F 000	<p>See Attachment A for the plan of Correction for FRI No. CA00623517, CA00639036, CA00639047, CA00639051, CA00639848, CA00639918, CA00639866, CA00640598, CA00621775, CA00638524, CA00621433</p>	

*Handwritten red stamp: AUG 19 2019*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Handwritten signature: Wojan G. Polkowski acting CEO*

8/9/2019

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.

*Handwritten note: 8/13/19 POE accepted. Wojan HFEM 1*

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F 000	<p>Continued From page 1</p> <p>40537, Health Facilities Evaluator Nurse. 40619, Health Facilities Evaluator Nurse. 29548, Health Facilities Evaluator Nurse. 26917, Pharmaceutical Consultant.</p> <p>The highest scope and severity was "L."</p> <p>An immediate jeopardy (IJ) was declared on 7/11/19 at 3:40 PM in the presence of the Acting Chief Executive Officer (CEO), Acting Director of Quality, Chief Nursing Officer (CNO), Quality Nursing Manager, and a Quality Nurse for F583, F600, F605 and F607:</p> <p>1. the facility's failure to protect 21 of 29 sampled residents from physical, mental, verbal, and sexual abuse, and chemical and physical restraints when:</p> <p>a. The facility did not identify incidents of abuse b. The facility failed to report incidents of abuse in a timely manner to the California Department of Public Health (The Department) and the responsible parties, and c. The facility failed to train staff as mandated reporters to report incidents of abuse directly and within 2 hours to the Department, the Ombudsman, and local law enforcement (refer to F607);</p> <p>2. 19 of 29 residents were photographed without their consent, three were photographed naked which had the potential to result in physical, mental or psychosocial harm and decline in physical, mental and psychsocial functioning of all residents in the facility (refer to F583);</p> <p>3. five of 29 residents received medications not</p>	F 000		

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F 000	Continued From page 2 prescribed by their physicians that resulted in five residents having life-threatening complications resulting in a significant decline in their physical functioning (refer to F605);  4. four of 29 residents were sexually abused, one of 29 residents was physically restrained, one of 29 residents was kicked by a staff member, and one of 29 residents was verbally demeaned and provoked to make inappropriate sexually explicit statements. These incidents put vulnerable residents at risk for physical, mental, or psychosocial harm and decline in physical, mental and psychosocial functioning (refer to F600).  The IJ was lifted on 7/12/19 at 6:36 PM after the facility presented an acceptable Plan of Correction (POC) and the survey team verified the implementation of the POC. The facility staff present were Acting CEO, Director of Quality from GACH 2, CNO, Quality Nursing Manager, and a Quality Nurse.	F 000			
F 583 SS=K	Substandard Quality of Care (SQC) at F600 - Free from Abuse and Neglect, F605 - Right to be Free from Chemical Restraints, F607 - Develop/Implement Abuse/Neglect Policies and F689 - Free of Accident Hazards/Supervision/Devices. Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)  §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583			

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F 583	Continued From page 3  §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.  §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights to privacy and confidentiality for 19 of 29 residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 18, 19, 20, 21, and 22), when photographs and videos of the residents were taken by two staff members (certified nursing assistant 2, and licensed vocational nurse 1) and shared through personal	F 583			

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F 583	<p>Continued From page 4</p> <p>cell phone text messages to other staff members, without the consent of the residents or their responsible party (RP, a person authorized to make decisions for another). See F600 for additional information regarding Residents 1, 3, 4, 10, 12, 13, and 14.</p> <p>This failure had the potential to result in embarrassment and emotional distress to 19 residents, preventing them from achieving and maintaining their highest practical level of well-being.</p> <p>Findings:</p> <p>Review of the document titled "Complaint/Incident Intake Report" indicated the facility left a voicemail (recorded message) on 2/6/19 at 5:45 PM, that videos and pictures of "naked" residents had been taken and exchanged among 2 staff members (certified nursing assistant 1 [CNA 1], CNA 2, and licensed vocational nurse 1 [LVN 1]), on their personal cell phones. The facility identified the residents that appeared in the videos and photographs. The list of the names of the residents in photographs and videos was provided on 5/29/19.</p> <p>During an interview with Chief Executive Officer (CEO), Director of Nursing (DON), Quality Manager (QM), and Deputy City Attorney (DCA) on 5/29/19 at 2:30 PM, CEO acknowledged the following, regarding the facility's review of the photographs and videos:</p> <ul style="list-style-type: none"> <li>- Residents have the right to be free of abuse and to consent to all photography before photographs are taken.</li> <li>- The photographs were not authorized by the residents or their RPs.</li> </ul>	F 583			

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F 583	<p>Continued From page 5</p> <p>- None of the residents (or their RPs) in the photographs and videos gave their consent to be photographed</p> <p>During a record review with Chief Executive Officer (CEO), Director of Nursing (DON), Director of Quality Management (DQM), Quality Manager (QM), and Deputy City Attorney (DCA), on 5/31/19 at 10:30 AM, 31 photographs and 15 videos were reviewed. CEO acknowledged that the images in the photographs and videos were of the identified 19 residents. CEO also acknowledged that in four photographs (of body parts) the residents could not be identified.</p> <p>Resident 1: Photograph 1 showed the exposed back and buttocks of Resident 1 during pericare. Photograph 2 showed the face of Resident 1 with his eyes closed, leaning to the side in a wheelchair. He was wearing a blue shirt with a white towel around his neck and had what appeared to be white rolled material tucked under his pants and the seatbelt. Photograph 3 showed a close up of the face of Resident 1. In the photograph the eyes of Resident 1 appeared to have bluish-blackish discoloration, his mouth was partially open.</p> <p>Resident 2: Photograph 4 showed Resident 2 sitting in a wheelchair staring straight ahead, wearing a blue shirt (partially opened), with a caregiver standing at his left side with her hand on his abdomen.</p> <p>Resident 3: Photograph 5 showed the face of Resident 3, with a white towel around her neck, covering her mouth and jaw. In the photograph Resident 3 also</p>	F 583		

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F 583	<p>Continued From page 6</p> <p>had a blue tourniquet (a device which applies pressure to an extremity to limit - the flow of blood) wrapped tightly around her left arm. Photograph 6, which was sent in a text message, showed a side profile of Resident 3, sitting in a chair and appeared to be holding something up to her mouth.</p> <p>Resident 4: Five videos showed Resident 4 being encouraged to make statements of a sexual nature.</p> <p>Resident 5: Photograph 7 showed Resident 5 lying in bed on his back with one staff member on each side of the bed. In the photograph the eyes of Resident 5 were closed, he was wearing a brown shirt and white pants with his legs spread apart with clear tubing coiled around his lower body and left foot.</p> <p>Resident 6: Photograph 8 showed the partial view of the face, with his eyes closed, sitting in a wheelchair, with black jacket covering his back.</p> <p>Resident 7: Photograph 9 showed Resident 7 leaning forward with his elbows resting on his knees and his forehead resting on top of his folded hands. In the photograph, Resident 7 was wearing blue pants and a black jacket.</p> <p>Resident 8: Photograph 10 showed Resident 8's buttocks with an open wound, with pinkish and foaming white discharge coming from the wound.</p> <p>Resident 9: Photograph 11 showed the face of Resident 9</p>	F 583		

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F 583	<p>Continued From page 7</p> <p>lying on his back in bed, wearing a hospital gown, with his eyes open and appeared to be looking to the left side.</p> <p>Resident 10: Photograph 12, identified as Resident 10, showed the resident on his side with his buttocks exposed. In the photograph a caregiver's hand can be seen administering a Fleet's enema to the resident.</p> <p>Resident 11: Three videos showed Resident 11 sitting in a wheelchair holding a can of beer and being asked by a staff member what he was holding in his hand and where he got it from.</p> <p>Resident 12: Two videos showed Resident 12 engaging in sexually explicit dialogue with staff.</p> <p>Resident 13: Photograph 13 showed Resident 13 sitting in a wheelchair at a table wearing a sweater and cap looking straight at the camera. Photograph 14 showed Resident 13 standing and leaning against a wall in a hallway. Photograph 15 showed Resident 13 lying in bed on his side bed with his legs hanging over the side of the bed. Photograph 16 showed resident 13 leaning against a wall in by the nurses' station wearing a hospital gown and red socks. Photograph 17 showed Resident 13 laying on his side on the floor near the nurses' station, wearing an open gown, socks and adult diaper. His back was exposed showing his adult diaper and left leg. Photograph 18 showed Resident 13 sitting on the</p>	F 583		

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F 583	<p>Continued From page 8</p> <p>floor near the nurses' station with his legs crossed, wearing a gown and shoes. Photograph 19 showed Resident 13 sitting on the floor in the hallway wearing a gown and red socks. Photograph 20 showed Resident 13 laying on his back on the floor in the hallway, with his gown pulled up above his waist. The photograph showed that he was wearing a soiled diaper and his entire legs were exposed. Photograph 21 showed Resident 13 sitting in a wheelchair with arms folded and his head resting. In the photograph Resident 13 was wearing a plaid shirt and tan cap.</p> <p>There were three videos of resident 13: Video one showed Resident 13 lying in bed on his side when he was suddenly kicked by a staff member on the back causing him to jerk. Video two showed Resident 13 leaning against a doorframe and clapping. Video three showed Resident 13 sitting on the edge of the bed and then falling backwards on the bed.</p> <p>Resident 14: Two videos showed Resident 14 laying in bed being agitated by a staff member to shout sexual obscenities. Also in the two videos, the staff member made derogatory statements directed to Resident 14. Photograph 22 showed Resident 14 laying in bed on his back with right arm reaching above his head, wearing red eyeglasses with his eyes open.</p> <p>Resident 18: Photograph 23 showed Resident 18 lying in bed with his right hand in his mouth. Photograph 24 and 25 showed Resident 18 in</p>	F 583		

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F 583	<p>Continued From page 9 bed holding a cup.</p> <p>Resident 19: Photograph 26 and 27 showed a close-up view of Resident 19's colostomy stoma (a surgically-made opening in the abdominal wall that allows for the expulsion of stool).</p> <p>Resident 20: Photograph 28 showed the face of Resident 20 sitting in a wheelchair behind a table with a black mug in front of him.</p> <p>Resident 21: Photograph 29 showed Resident 21 in the background sitting in a wheelchair facing away from the camera.</p> <p>Resident 22: Photograph 30 showed Resident 22 in the background sitting in a wheelchair facing a table with partial view of his face.</p> <p>Unidentified Residents Four photographs of body parts of unidentified residents (no faces or other identifying marks in the photographs). One Photograph 31 showed a resident's buttocks with an open reddish colored wound. Photograph 32 showed a resident's left foot with four toes blacken in color. Photograph 33 showed a resident's buttocks with an open pinkish colored wound. Photograph 34 showed a resident's swollen feet.</p> <p>During an interview with Chief Executive Officer (CEO), Director of Nursing (DON), Director of Quality Management (DQM), Quality Manager (MQ), and Deputy City Attorney (DCA), on</p>	F 583		

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F 583	<p>Continued From page 10</p> <p>5/31/19 at 10:30 PM, the following statements were made:</p> <p>DON stated, "This (referring to the white cloth covering the face of Resident 3) is not acceptable practice. Our policy does not allow for this kind of restraint or procedure management." CEO stated, there was no consent for the photographs and videos. DQM stated, "This is substantiated as sexual abuse because there is nudity." DON stated, "No this is not a dignified manner." CEO stated, "The staff should be returning ... (Resident 13) to bed, not taking pictures ... in a state of undress." DQM stated, "This is substantiated as physical abuse ... it definitely happened."</p> <p>Review of nursing education training document titled "2018 Mandatory for All: Residents Rights and Abuse Prevention (Preservation of Dignity, Including Provisions of Dignity, and Abuse Prevention) - Live Class for CNAs/PCAs/HHAs" dated 4/2/2018 -4/6/2018, indicated "...Residents' Rights...Personal and Privacy Rights (Dignity, Respect, and Freedom)...Rights Regarding Abuse...Personal and Privacy Rights...Residents rights are posted in the glass bulletin boards on every neighborhood (areas where residents rooms are located)...Residents have the right to:...Privacy...In your work practice, you are to: Treat the resident's room as their home...Ask permission and tell the resident what you are going to do before ..."</p> <p>Review of a facility policy titled "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response" dated 5/8/18 indicated "[Facility name] shall promote an</p>	F 583			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/12/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAGUNA HONDA HOSPITAL &amp; REHABILITATION CTR D/P SNF</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>375 LAGUNA HONDA BLVD.</b> <b>SAN FRANCISCO, CA 94116</b>		
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F 583	Continued From page 11 environment that enhances resident well-being and protects residents from abuse...Definition: 1. Abuse" is defined...It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled though the use of technology..."  An immediate jeopardy (IJ) was declared on 7/11/19 at 3:40 PM in the presence of the Acting Chief Executive Officer (CEO), Acting Director of Quality, Chief Nursing Officer (CNO), Quality Nursing Manager, and a Quality Nurse when 19 of 29 residents were photographed without their consent, three were photographed naked which had the potential to result in physical, mental or psychosocial harm and decline in physical, mental and psychosocial functioning of all residents in the facility.  The IJ was lifted on 7/12/19 at 6:36 PM after the facility presented an acceptable Plan of Correction (POC) and the survey team verified the implementation of the POC.The facility staff present were Acting CEO, Director of Quality from GACH 2, CNO, Quality Nursing Manager, and a Quality Nurse.	F 583			
F 600 SS=K	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.	F 600			

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F 600	Continued From page 12  §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 protect seven of 29 sampled residents (Residents 14, 13, 12, 10, 4, 3 and 1) from verbal, physical and mental abuse when; 1. Resident 14, was verbally abused, provoked, and humiliated by a staff member. 2. Resident 13, was physically abused, by being kicked on the buttocks by facility staff. 3. Resident 12 and Resident 4, were sexually abused, when facility staff engaged the residents in conversations of a sexual nature. 4. Resident 10 was sexually abused, when a photograph was taken with their buttocks exposed. 5. Resident 3, was mentally and physically abused, when a towel was tied over her mouth by a staff member as a restraint. 6. Resident 1 was sexually abused, when a photograph was taken with the resident's back, buttocks and genitals exposed during perineal care.  These failures resulted in physical, verbal, sexual and mental abuse for Residents 14, 13, 12, 10, 4, 3 and 1; with potential for physical, mental or psychosocial harm and decline in physical, mental and psychosocial functioning for all residents under the care of LVN 1, CNA 1, and CNA 2, by not ensuring their safety and well-being in an environment free from abuse.	F 600			

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F 600	Continued From page 13  Findings:  Review of document titled "Complaint/Incident Intake Report" indicated the facility left a voicemail (recorded message) on 2/6/19 at 5:45 PM that videos and pictures of "naked" residents had been taken and exchanged among 3 staff members (certified nursing assistant 1 [CNA 1], CNA 2 and licensed vocational nurse 1 [LVN 1]), on their personal cell phones. The facility identified the residents that appeared in the videos and photographs. The facility provided the list of the names of the residents in photographs (Residents 1 , 3, 10, and 13) and videos (Residents 4, 12, 13, and 14) on 5/29/19.  1. Review of the clinical record for Resident 14, indicated Resident 14 was admitted 09/29/15, with diagnoses of traumatic brain injury, seizures, left hemiplegia (Muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles). Review of the most recent comprehensive Mlinimum Data Set (MDS), an assessment tool, dated 5/9/19 indicated he was dependent on staff assistance for activities of daily living like mobility, transferring from and to bed, dressing, eating, personal hygiene, bathing, and fully dependent on staff for toileting. The brief interview for mental status (BIMS, a short scanner to help detect cognitive (intellectual activity such as thinking, reasoning, remembering) impairments (loss of function) indicated a score of 10 (maximum score of 15 with 13 to 15 no cognitive defects, 8 to 12 mild cognitive defect, 0 to 7 severe cognitive defect).  Review of the facility's digitally encrypted files of	F 600		

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F 600	<p>Continued From page 14</p> <p>photos, videos, and text messages from the personal cellular phones of LVN 1, CNA 1, and CNA 2, included two undated short video segments of Resident 14 lying in bed covered with a blanket, eyeglasses on and fully awake. CNA 2 is heard agitating Resident 14 to get a response and making derogatory statements. CNA 2 is heard on the video asking Resident 14 "what does the [REDACTED] mean...?", in reference to the resident's first initial of his last name. Resident 14 answered by giving his full name, followed by CNA 2 stating "I thought it meant [REDACTED]..." (a slur in Spanish for a gay man). The videos also showed CNA 2 asking Resident 14, four times if he wanted a towel to wipe "the cum off ...". These statements by CNA 2 provoked an immediate strong emotionally angry response from Resident 14, which was exhibited by Resident 14 screaming profanities in both English and Spanish and moving his hands.</p> <p>During an interview with the Nurse Manager (NM 1) on 6/10/19 10:20 AM, he stated " There were two videos of Resident 14 that were taken by [CNA 2]. In the first week of May [2019], I saw a video in which a Patient Care Assistant is seen going inside [Resident 14]'s room, [CNA 2] ... said some things in a different language, not nice words from [CNA 2], abusive words...provoking him to say things...[Resident 14] became angry, yelling to [CNA 2] to get out of his room...A second video showed [CNA 2] ...offering [Resident 14] a towel and asking him if he wanted to wipe his cum off...[Resident 14] became angry yelling in English and Spanish..." NM 1 did not elaborate when asked on more specifics of contents of words used by CNA 2. When asked about the videos, NM 1 stated "They were on staff's cell phones...The only reason these</p>	F 600		

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F 600	<p>Continued From page 15</p> <p>incidents came out is because a staff member complained to me of sexual harassment from another staff member...and these [the videos] were found...Yes, all staff is trained annually for abuse prevention and reporting; the staff members involved with the videos and photos of residents did not report the incidents..."</p> <p>During a 6/10/19 1:45 PM interview with Resident 14, when asked about any specific information about his previous comments around staff, he stated " I don't want to talk about bad stuff...I barely remember what happened."</p> <p>During an interview with the Chief Executive Officer (CEO), the Director of Nursing (DON), the Quality Management Director (DQM), and a City Attorney (CA); on 6/19/19 12:30 PM; DON and DQM acknowledged the video recordings found on CNA 2 and LVN 1's cell phones showed Resident 14 was "...abused by [CNA 2]...". DON stated "...yes, some of the incidents are possibly a crime against residents, we reported them to law enforcement when we became aware...". CEO stated "...I wish all of these [incidents] were reported in 2016 when some of the residents pictures were taken...we are failing at reporting...If we had a safety culture, reporting would have happened three years ago...". DQM stated "...It has been mind blowing these incidents happened...we did not see any signs..."</p> <p>2. Review of clinical record for Resident 13 indicated Resident 13 was admitted 10/10/08 with diagnosis that included anoxic encephalopathy (condition resulting from brain being deprived of oxygen) resulting in cognitive impairment with mental capacity of a seven-year-old. Review of the MDS dated 1/18/19, indicated, Resident 13</p>	F 600		

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F 600	<p>Continued From page 16</p> <p>had a BIMS score of 12 which indicated, moderate cognitive defect.</p> <p>Review of the facility's digitally encrypted files of photos, videos and text messages from the personal cellular phones of LVN 1, CNA 1, and CNA 2, included one video dated, 1/8/16 at 9:32 AM, of Resident 13 lying in bed. The video showed Resident 13 lying on his side in bed and suddenly being kicked on the buttocks by a staff member (the only thing seen of the staff member was the leg and foot wearing a black boot), causing the resident to jerk.</p> <p>During a concurrent interview with Director of Quality Management (DQM), on 5/31/19 at 10:30 AM, DQM stated "This is substantiated as physical abuse ... it definitely happened."</p> <p>3. Review of the clinical record for Resident 12 indicated Resident 12 was admitted 6/5/17 with diagnosis of schizoaffective disorder (mood disorder such as mania and depression). Review of the MDS dated 9/18/17 indicated a BIMS score of 15 no cognitive defect.</p> <p>Review of the facility's digitally encrypted files of photos, videos and text messages from the personal cellular phones of CNA 1 and CNA 2, included two videos, dated 8/5/17 at 9:36 AM and 9:39 AM, that showed Resident 12 engaged in sexually explicit dialogue with staff.</p> <p>During an interview with Director of Quality Management (DQM), on 5/31/19 at 10:30 AM, DQM stated, "This is substantiated as abuse."</p> <p>4. Review of the clinical record for Resident 4 indicated Resident 4 was admitted 5/24/16 with</p>	F 600		

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F 600	<p>Continued From page 17</p> <p>diagnosis of stroke (CVA, blood supply to part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients). Review of the MDS dated 12/13/19 indicated a BIMS score of 15.</p> <p>Review of the facility's digitally encrypted files of photos, videos and text messages from the personal cellular phones of CNA 1 and CNA 2, included six videos that showed Resident 4 being directed to use inappropriate language. Four of the six videos, dated 8/3/18 from 7:15 PM to 8:10 PM, showed Resident 4 being questioned by CNA 1 on sexual practices. A fifth video, dated 8/4/18 at 7:42 PM, showed Resident 4 being prompted to sexually explicit remarks. A sixth video, dated 8/3/18 at 8:54 PM, showed staff borrowing money from Resident 4.</p> <p>5. Review of the clinical record for Resident 10 indicated Resident 10 was admitted 1/23/19 with diagnosis of cellulitis (potentially serious bacterial skin infection). Review of the MDS dated 2/6/19 indicated a BIMS score of 15.</p> <p>Review of the facility's digitally encrypted files of photos, videos and text messages from the personal cellular phones of CNA 1 and CNA 2, included one photograph, dated 7/27/18 at 11:34 AM, that showed Resident 10 lying in bed. In the photograph, Resident 10 was lying on his side with his buttocks exposed, his face was not visible. In the photograph a caregiver's hand can be seen administering a "Fleet's enema" (a saline laxative that cause an immediate bowel movement) to the resident.</p> <p>During an interview with Director of Nursing (DON) and DQM on 5/31/19 at 10:30 AM, DON</p>	F 600		

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F 600	<p>Continued From page 18</p> <p>stated, that nude photography of residents without consent is sexual abuse. DQM stated "This is substantiated as sexual abuse because there is nudity."</p> <p>6. Review of the clinical record for Resident 3 indicated resident 3 was admitted 12/24/15 with diagnosis of hyponatremia (low sodium blood levels). MDS dated 12/3/18 indicated Resident 3 cognitive skills for daily decision making was moderately impaired.</p> <p>Review of the facility's digitally encrypted files of photos, videos, and text messages from the personal cellular phones of LVN 3 and CNA 1, included a photograph of Resident 3, dated 4/3/18 at 1:09 PM, showing Resident 3 with a white towel tied around her mouth. In the photograph a blue tourniquet (a device which applies pressure to an extremity to limit -the flow of blood) can be seen wrapped around her left upper arm.</p> <p>During an interview with the Chief Executive Officer (CEO), on 6/5/19, at 2:00 PM, in her office, CEO stated "... [Resident 3] was identified in two photographs... one of which was being restrained by the hands of staff, with a white cloth towel around the face covering the mouth, while the eyes and upper face are grimacing A tourniquet wrap around the left upper arm, might be happening because of an intravenous insertion...This is not acceptable practice..."</p> <p>7. Review of the clinical record for Resident 1 indicated Resident 1 was admitted 5/9/18, with diagnosis status post laminectomy (surgical procedure that removes a portion of the vertebral bone). Review of the MDS, dated 11/19/18,</p>	F 600		
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F 600	<p>Continued From page 19 indicated a BIMS of 3 indicating severe cognitive defect.</p> <p>Review of the facility's digitally encrypted files of photos, videos and text messages from the personal cellular phones of LVN 1 and CNA 1, included a photograph of dated 7/3/18 at 4:37 PM, of Resident 1 lying in bed. The photograph showed Resident 1 lying on his side with his buttocks and genitals exposed during perineal care with three unidentified staff members present.</p> <p>During an interview with the DON on 5/29/19 at 2:30 pm, DON stated that nude photography of residents without consent is sexual abuse.</p> <p>Record review of staff "Read and Sign" for "Residents Rights &amp; Abuse Prevention (Preservation of Dignity, Including Provision of Dignity and Abuse Prevention) - Live Class for CNAs/PCAs/HHAs" didactic material for the week of 4/2/18 to 4/6/18, included signatures from all CNAs, PCA, and HHAs who attended the class including CNA 2 and CNA 1.</p> <p>Record review of staff "Read and Sign" for "Prevention, Investigation, &amp; Reporting of Abuse and Accidents" didactic material for the week of 9/4/18 to 9/12/18 indicated signatures from all staff who attended the class including CNA 2 and CNA 1, LVN 1, LVN 3.</p> <p>The facility policy and procedure titled "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response" dated September 11, 2018 indicated: "[Facility name] shall promote an environment that enhances resident well-being and protects</p>	F 600		
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F 600	<p>Continued From page 20</p> <p>residents from abuse...Policy 1. employees ...shall strive to protect residents from physical, psychological, fiduciary and verbal abuse and neglect...Purpose: 1. To protect the resident from abuse...2. To report incidents of alleged violations of abuse...5. To meet reporting requirements as mandated by federal and state laws and regulations...Education...b. Employees are obliged to report any reasonable suspicion of abuse against a resident to a law enforcement agency...</p> <p>Definition: 1. Abuse" is defined ... as "the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish ... Instances of abuse of all resident, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled though the use of technology...</p> <p>Reporting. a. The facility mandates staff to report suspected abuse to the local Ombudsman... b. The facility also requires employee, manager, agent or contractor ...to report to the...Sheriff ' s Department any reasonable suspicion of a crime committed against a resident of [Facility Name] ... c. The nurse manager, charge nurse, and nursing supervisor shall communicate to inform one another of the alleged abuse.... ...ii. Immediately inform the resident and /or surrogate decision maker that the abuse allegation is being taken seriously; identify for the resident and/or surrogate decision maker the steps being taken to provide for the resident's safety; and assure the resident and/or the surrogate decision maker that an investigation is being conducted...</p>	F 600		

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F 600	<p>Continued From page 21</p> <p>i. This policy designates the Director of QM [Quality Management] as the primary mandated reporter for [facility name] ...The Director of QM or designee ensures that allegations of resident abuse are reported to the Ombudsman, Sheriff ' s Department, and CDPH..."</p> <p>The California Welfare and Institute Code 15630 (a) indicated "Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."</p> <p>The Federal Elder Justice Act indicated "All instances of suspected crimes committed against residents or others receiving care in long term care health facilities (skilled nursing facilities) receiving at least \$10,000 per year in Medicare / Medicaid funds, must be reported, by the facility, to at least one local law enforcement agency and to the Licensing and Certification Program of the California Department of Public Health..."</p> <p>An immediate jeopardy (IJ) was declared on 7/11/19 at 3:40 PM in the presence of the Acting Chief Executive Officer (CEO), Acting Director of Quality, Chief Nursing Officer (CNO), Quality Nursing Manager, and a Quality Nurse for the facility's failure to protect 21 of 29 sampled residents from physical, mental verbal, and sexual abuse and chemical and physical</p>	F 600		

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F 600	Continued From page 22 restraints when:  1. The facility did not identify incidents of abuse 2. The facility failed to report incidents of abuse in a timely manner to the California Department of Public Health (The Department) and the responsible parties, and 3. The facility failed to train staff as mandated reporters to report incidents of abuse directly and within 2 hours to the Department, the Ombudsman, and local law enforcement.  The IJ was lifted on 7/12/19 at 6:36 PM after the facility presented an acceptable Plan of Correction (POC) and the survey team verified the implementation of the POC. The facility staff present were Acting CEO, Director of Quality from GACH 2, CNO, Quality Nursing Manager, and a Quality Nurse.	F 600		
F 605 SS=K	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)  §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:  §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).  §483.12 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	F 605		

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F 605	<p>Continued From page 23</p> <p>any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to ensure that residents were free from chemical restraints when licensed vocational nurse 1 (LVN 1) with certified nursing assistant 1 (CNA 1) intentionally administered non-prescribed medications to five of five residents (Resident 2, Resident 6, Resident 11, Resident 24, and Resident 25) for staff convenience. This failure resulted in Residents being hospitalized for over-sedation, respiratory depression, and/or altered mental status.</p> <p>Findings:</p> <p>1. A review on 6/19/19 of Resident 2's General Acute Care Hospital 1 (GACH 1) Clinical Record indicated that Resident 2 had past medical history of cognitive deficits, dementia, Huntington's Disease (progressive break down of nerve cells), schizophrenia (mental disorder), and limited ability to communicate. Resident 2 presented with altered mental status, respiratory depression, and somnolence on 1/8/19 and was transferred</p>	F 605		
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F 605	<p>Continued From page 24 from the facility to GACH 1.</p> <p>A review on 6/19/19 of Resident 2's GACH 1 History and Physical Note, dated 1/8/19, indicated "Patient was seen in usual state of health on 1/8 in the am ...during lunch time, he was noted to be somnolent and difficult to arouse with a O2 sat of 83%...Per EMS, patient had a breathing rate of 1-2 breaths per minute. He was bagged by EMS ...Patient was somnolent and with pinpoint pupils. He was hypoxic with agonal breathing on ED arrival and he was given 2 mg of naloxone (a medication used to reverse the effects of opioids) with spontaneous respirations after that. Per [facility] nurse...He did not have opiates on his med list and no recent one time doses. He does not have visitors or family...He is mostly bedbound with low functionality..."</p> <p>A review on 6/19/19 of Resident 2's GACH 1 toxicology drug screen collected on 1/8/19 at 6:55 PM indicated the following positive test results: *Morphine *EDDP (Methadone Metabolite) *Methadone</p> <p>A review on 6/19/19 of Resident 2's facility Medication Administration Record (MAR) indicated that Resident 2 did not have physician orders for Morphine or Methadone recently or on 1/8/19.</p> <p>A review on 6/19/19 of Resident 2's GACH 1 Discharge Summary, dated 1/10/19, indicated "resident...presently admitted for AMS (Altered Mental Status) with respiratory depression, found to have urine toxicology screen positive for unprescribed opioids, w/comprehensive tox showing methadone...morphine; improved</p>	F 605			

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F 605	<p>Continued From page 25</p> <p>w/Narcan and now back at clinical baseline. (Dx:toxic encephalopathy.) Team has spoke with LHH providers who are investigating the situation (pt doesn't get visitors and is not interactive enough to be surreptitiously using narcotics from another pt, so it's unclear how he would've gotten these meds into his system..."</p> <p>A review on 6/27/19 of Resident 2's Medical Doctor 4 (MD 4) Re-Admission Progress Note, dated 1/15/19, indicated "Opioid Intoxication:Patient found having...Methadone and Morphine in mass Spectrometry which aren't in his medication list. Patient almost had respiratory arrest because of this. I am not sure how these medication got in patient system but this [is a]serious issue...I am not sure there are any medication errors in this case because I didn't find any patients on all three meds at his household. Patient had sitter 16/24 [sitter for two 8 hour shifts]. Missing coach in AM shift. Patient got altered during day shift and got to the point that he got altered and later Respiratory depression. We'll have 24/7 sitter from now on. The nursing would reinforce Monitoring visitors. Nursing would work on Med Pass quality..."</p> <p>During an interview on 6/19/19 at 10:11 AM, Medical Doctor 8 (MD 8) stated she was the attending physician during Resident 2's care at GACH 1. She also stated that Resident 2 could have died from the Morphine and Methadone. She was confident that the cause of the AMS and respiratory depression was due to the Morphine and Methadone and there were no other possibilities for Resident 2's symptoms. She also said that the team was extremely concerned about opioid intoxication and the care at the facility that she kept Patient 2 at GACH 1 for one</p>	F 605		
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F 605	<p>Continued From page 26</p> <p>week. She did not want to send Resident 2 "to her death" because she had heard of several similar incidences at the facility.</p> <p>2. A review on 6/27/19 of Resident 6's clinical record indicated that on 2/13/18, Resident 6 presented with respiratory depression and hypoxemia. Resident 6 was then transferred from the facility to GACH 1. A review on 6/17/19 of Resident 6's GACH 1 Emergency Department Summary dated 2/13/18, indicated "Acutely altered during at 2215 at [facility]. PT normally fully responsive. Staff denied trauma. PT bagged en route. Agonal respirations upon arrival and prep for intubation...Altered mental status, unspecified altered mental status type, acute respiratory failure with hypoxia and hypercapnia...consider opiate OD however pt is not on opiates at LHH...1 mg Narcan given w/some increased LOC...became agitated and followed some basic commands..." A review on 6/17/19 of Resident 6's GACH 1 Discharge Summary dated 2/15/18 indicated "I had previously emailed LHH Medical Director...on 2/26/18 of our team's concerns about this pt's worrisome presenting clinical circumstances, who replied that an internal investigation was underway. I additionally emailed him on 3/5/18 to share the final report of the initially requested comprehensive toxicology report..." A review of Resident 6's GACH 1 toxicology reported dated 2/13/18, indicated that Resident 6's urine tested (+) for Methadone, Morphine, Tramadol, Gabapentin, and Quetiapine [All medications that can cause sedation; Methadone, Morphine, Tramadol can cause respiratory depression]. A review on 7/2/19 of the LHH clinical record indicated that Resident 6 was not prescribed any of these medications.</p>	F 605			

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F 605	<p>Continued From page 27</p> <p>A review on 7/3/19 of Resident 6's clinical record indicated on 10/26/18 Resident 6 was transferred to GACH 2 for mental status changes. A review on 7/3/19 of the GACH 2 Emergency Department Summary dated 10/26/18 indicated "CHIEF COMPLAINT: Patient presents for evaluation of mental status change, motor deficits, facial droop...Resident 6 was seen in the GACH 2 ED for facial droop and change in mental status...There were benzodiazepines in his urine, which may explain his altered mental status..." A review on 7/3/19 of the GACH 2 Physician Progress Note dated 10/30/18, indicated "His urine tox was + for benzodiazepines (which are NOT on his med list). Over the next several hours in the ER he eventually improved in his mental status and was felt to be at baseline. He returned to LHH with suspected cause of the AMS to be benzo intoxication...Urine tox screens will be done 3 x/week for surveillance. A review on 7/3/19 of Resident 6 clinical record confirmed that prior to the ED visit Resident 6 did not have any prescribed benzodiazepines (sedative medications).</p> <p>During an interview on 7/5/19 at 10:40 AM Resident 6 stated that he never took those medications that he had tested (+) as mentioned above. He also stated that he never saw other residents, residents' family, or residents' friends give medications to any residents. He said that only Laguna Honda staff gave medications to him.</p> <p>3. A review on 6/27/19 of Resident 24's GACH 1 clinical record indicated Resident 24 was transferred to GACH 1 from Laguna Honda Hospital on 8/30/18 for respiratory failure. A</p>	F 605		

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F 605	<p>Continued From page 28</p> <p>review of the Discharge Summary dated 9/8/18 indicated "presented from [facility] in respiratory failure...She was found to be hypoxic in resp distress at 6:20 pm...O2 sat 86-88% on bag valve mask which improved...Mass spect send out tox returned...medications not on her formulary that was detected was methadone as well as tramadol. That was discussed with her niece who is the closest family member to her and it is still unclear when she would have taken either of these medications. These meds could have caused RR depression..."</p> <p>During an interview on 7/5/19 at 12:00 PM, Resident 24 stated that she never took those medications that he had tested (+) as mentioned above. She also stated that she never saw other residents, residents' family, or residents' friends give medications to any residents. She said that only Laguna Honda staff gave medications to her.</p> <p>4. A review on 6/27/19 of Resident 25 clinical record, indicated that on 12/25/18 Resident 25 presented with over sedation and transferred to GACH 2. A review on 7/3/19 of Resident 25's GACH 2 Emergency Record dated, 12/25/18, indicated "Complaint: ams[altered mental status]...decreased loc[level of consciousness] this am...6am this am she was noted to have AMS this am...Mental Status: Hypo-arousable...Vital signs reviewed...difficult to arouse." A review on 7/3/19 of the Discharge Instructions dated 1/1/19 indicated "Dear Resident 25...You were admitted to the hospital for confusion and sleepiness. This required you to be monitored in the ICU with breathing support...You had high level of a medication called Neurontin (Gabapentin) in your blood, which we think is what made you confused. We</p>	F 605		

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F 605	<p>Continued From page 29</p> <p>do not know how this medication got into your system..." A review on 7/3/19 of the Resident 25's GACH 2s toxicology lab results indicated that Resident 25 was (+) for Mirtazapine and Gabapentin (medications that cause sedation). A review on 7/3/19 of Resident 25's Laguna Honda Medication list indicated that Mirtazapine and Gabapentin were not prescribed for Resident 25 prior to the GACH 2 ED visit. There were orders for a repeat toxicology for Mirtazapine and Gabapentin upon Resident 25's return to Laguna Honda Hospital. On 1/7/19 Resident tested positive again for Gabapentin despite no physicians orders for Gabapentin.</p> <p>During an interview on 7/5/19 at 10:30 AM Resident 25 stated that she never took those medications that he had tested (+) as mentioned above. She also stated that she never saw other residents, residents' family, or resident's friends give medications to any residents. She said that only Laguna Honda staff gave medications to her.</p> <p>5. A review on 6/27/19 of Resident 11's clinical record indicated physicians orders for a weekly urine toxicology because of concerns with (+) toxicology results. The following are (+) toxicology results:            *1/17/18 Morphine-No physicians orders for Morphine            *2/16/18 Methadone-No physicians orders for Methadone            *2/24/18 Oxycodone-No physicians orders for Oxycodone            *2/28/18 Oxycodone and Morphine-No physicians orders for Oxycodone and Morphine            *6/18/18 Morphine-No physicians orders for Morphine            *7/2/18 Morphine and Methadone-No physicians</p>	F 605			

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F 605	<p>Continued From page 30</p> <p>orders for Morphine and Methadone</p> <p>*8/2/18 Methadone-No physicians orders for Methadone</p> <p>*8/6/18 Methadone-No physicians orders for Methadone</p> <p>*9/2/18 Resident 11 expired</p> <p>Resident 2, Resident 6, Resident 24, Resident 25, and Resident 11 all had (+) urine toxicology screens for medications that caused respiratory depression, over sedation, and/or altered mental status. All of these Residents did not have physicians orders for the medications that were found in the urine.</p> <p>During an interview on 7/3/19 at 10:00 AM GACH 2 LAB Staff 1 (LS 1) stated that the following medications are undetectable in the urine after the following number of days:</p> <ul style="list-style-type: none"> <li>*Benzodiazepines (Sedative)-2 weeks</li> <li>*Morphine Sulfate(Opioid)-3 days</li> <li>*Methadone (Opioid)-4 days</li> <li>*Oxycodone(Opioid)-3 days</li> <li>*Gabapentin (anti-seizure medication, cause sedation)-Dose dependent varies</li> <li>*Mirtazapine (antidepressant, cause sedation)-Dose dependent varies</li> <li>*Quetiapine (antipsychotic, cause sedation)-Dose dependent varies</li> </ul> <p>During an interview on 7/5/19 at 11:50 AM the Quality Management Nurse Manager (MGM) stated that there were multiple reported cases of (+) urine toxicology results for patients that were not prescribed the medications found in the urine. She also stated that she would provide all of the reported cases. A review on 7/5/19 of the entitled document North 1 Staffing for Licensed Nurses indicated the dates of all positive toxicology</p>	F 605		
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F 605	Continued From page 31 results without Physicians orders followed by LVN 1 and CNA 1 staffing shift assignments: *1/8/19 Resident 2 (+) Methadone, Morphine-LVN 1 worked on 1/8; both worked the day before *2/13/18 Resident 6 (+) Methadone, Morphine, Tramadol, Gabapentin, and Quetiapine-Both worked on 2/13 and 2/12 *10/26/18 Resident 6 (+) Benzodiazepine-LVN 1 worked on 10/26; both worked the day before *11/2/17 Resident 11 (+) Methadone-CNA 1 worked on 11/2 and on 11/1 *1/17/18 Resident 11 (+) Morphine-Both worked on 1/17 however LVN 1 was in class; Both worked the day before LVN 1 was in class *2/16/18 Resident 11 (+) Methadone-LVN 1 worked on 2/16 and 2/15 *2/24/18 Resident 11 (+) Oxycodone-LVN 1 work on 2/24 and 2/23 *2/28/18 Resident 11 (+) Oxycodone and Morphine-CNA 1 worked on 2/28 and 2/27 *6/18/18 Resident 11 (+) Morphine-Both worked on 6/18 and 6/19 *7/2/18 Resident 11 (+) Morphine and Methadone-Both worked 7/2; CNA 1 worked 7/1 *8/2/18 Resident 11 (+) Methadone-Both worked 8/2 and 8/1 *8/6/18 Resident 11 (+) Methadone-CNA 1 worked 8/6; both worked 8/5 *8/30/18 Resident 24 (+) Methadone-Both worked 8/30 and 8/29 *12/25/18 Resident 25 (+) Gabapentin & Mirtazapine-Both worked 12/25; CNA 1 worked 12/24 *1/7/19 Resident 25 (+) Gabapentin-Both worked 1/7 and 1/6  The above indicated that either one or the other (LVN 1, CNA 1), or both, were present when Resident 2, Resident 6, Resident 24, Resident	F 605			

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F 605	<p>Continued From page 32</p> <p>25, and Resident 11 all had (+) urine toxicology screens for medications that caused respiratory depression, over sedation, and/or altered mental status. All of these Residents did not have physicians orders for the medications that were found in the urine. Either LVN 1 or/and CNA 1 were present in all of the reported cases.</p> <p>During an interview on 07/02/19 at 10:13 AM North Nurse Manager 1 (NM 1) stated that LVN 1 was a competent nurse he would rate his ability above average at 3.5 out of 5 stars (5 being great). LVN 1 was knowledgeable about hospital policy and procedures. During the time NM 1 managed LVN 1 he had no disciplinary action against LVN 1. NM 1 did not believe that the positive toxicology screens were multiple medication errors made by LVN 1.</p> <p>During an interview on 07/02/19 at 10:44 AM North Nurse Manager 2 (NM 2) stated that LVN 1 was a competent nurse. She was not aware of any medical errors issues or disciplinary action that involved LVN 1. She said that LVN 1 was a competent nurse and did not believe the positive toxicology screens were multiple medication errors made by LVN 1.</p> <p>During an interview on 07/02/19 at 11:22 AM the Director of Merit and Staffing Resources (DMSR) stated that LVN 1 worked at Laguna Honda Hospital from 12/10/12 through 5/6/19 as an LVN. She also stated LVN 1 passed all his medication pass and medication safety competencies. DMSR said that when nurses pass the competencies that meant that they were knowledgeable about medication safety and about how to safely administer medications.</p>	F 605			

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F 605	<p>Continued From page 33</p> <p>During an interview on 7/2/19 at 11:58 AM the Quality Management Nurse Manager (QM 1) stated that LVN 1 did not have any medication errors reported within the last 5 years through their incident reporting system (system in which staff can report hospital incidences which included medication errors).</p> <p>During an interview on 7/2/19 at 1:00 PM the Director of Pharmacy (DOP) stated that LVN 1 was drugging Residents. The DOP also stated that LVN 1 most likely was taking patients medications to give to other patients. The DOP said that LVN 1 texted a pictures to CNA 1 holding a bag of medications. The DOP believed that LVN 1 would take one patients medication and put them in a bag to later give other patients that were not prescribed these medications. The DOP said there is a large population of cognitively impaired patients in the North wing and some of the patients would not know that they had not received their medication and some other patients would not know if they were taking the wrong medication. During an interview on 7/2/19 at 11:58 AM QM 1 stated there was approximately 40% of patients in the North wing that were cognitively impaired. During an interview on 7/2/19 at 3:00 PM the DOP stated that late wastage was commonly found in opioid diversion. There were three incidences in which narcotic were not documented promptly by LVN 1 and the narcotics were wasted late. When narcotics are wasted late this would give the nurse an opportunity to substitute the narcotic, for example with saline, and divert the narcotic. She also stated it was possible this was another way LVN 1 may have diverted.</p> <p>A review on 7/2/19 of the document entitled</p>	F 605		

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F 605	<p>Continued From page 34</p> <p>MAKE HIM SLEEP TEXT EXCHANGE 1-16-18 indicated the following text exchange between LVN 1 and CNA 1 on 1/16/18 at 3:09 PM through 8:32 PM:</p> <ul style="list-style-type: none"> <li>*Where are you-CNA 1</li> <li>*N2 [North Wing Level 2]-LVN 1</li> <li>*They need a RN-LVN 1</li> <li>*Who are you coaching?-LVN 1</li> <li>*Resident 15. But not until 4 p.m.-CNA 1</li> <li>*Ok-LVN 1</li> <li>*RN 7 is your nurse-LVN 1</li> <li>*Shes stupid-CNA-1</li> <li>*Make him sleep-CNA 1</li> <li>*Very much so!-LVN 1</li> <li>*I'm going down later encourage him to take his white pills-LVN 1</li> <li>*Kiss and Heart emoji-CNA 1</li> <li>*Thanks-CNA 1</li> <li>*White pills! White pills!-LVN 1</li> <li>*Smiley Face emoji -LVN 1</li> <li>*I already have the white meds-LVN 1</li> <li>*Let me know if you are already in N1 [North Wing Level 1]-LVN 1</li> <li>*Yes of coarse!-CNA 1</li> </ul> <p>The document indicated that CNA 1 asks LVN 1 to make Resident 15 sleep and then says nurse on duty was stupid. The document also indicated LVN 1 did not enter the medication room where Resident 15 was a patient, he could not have accessed Resident 15's prescribed medications but LVN 1 still had the white pills.</p> <p>A review on 7/2/19 of the document entitled Salamat Mercury Text Exchange indicated the following text exchange between LVN 1 and CNA 1 on 7/10/18 at 5:37 PM through 5:41 PM:</p> <ul style="list-style-type: none"> <li>*Picture of Resident 1 in a wheel chair hunched over sleeping-LVN 1</li> <li>*What is he doing?-LVN 1</li> </ul>	F 605		

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F 605	<p>Continued From page 35</p> <p>*Asleep! lol-CNA 1 *Hahaha-LVN 1 *He's asleep-CNA 1 *Thanks to Mercury!-LVN 1 *Lol-CNA 1</p> <p>The above indicated a reference to Mercury drugstore commonly found in the Philippines. Mercury appears to be code for drugs. The text exchange would then mean that Resident 1 was sleeping thanks to being drugged.</p> <p>A review on 7/2/19 of the document entitled Tago Mo Chocolates Text Exchange indicated the following text exchange between LVN 1 and CNA 1 on 5/21/18 at 6:52 AM through 6:56 AM: *Where are you at?-LVN 1 *I have asthma big brother LVN 1-CNA 1 *Too bad ...I got all the ...-LVN 1 *All the?!-CNA 1 *What?-CNA 1 *Actual pictures of chocolates-LVN 1 *Actual picture of three vials of Lorazepam held by LVN 1 (drug for sleep, anxiety)-LVN 1 *Awww ...lol ...Please hide my chocolates. Hahaha-CNA 1</p> <p>The document also indicated that the pictures of the chocolates and Lorazepam were sent at the same time on 5/21/18 at 6:56 AM.</p> <p>The above indicated that chocolates were code for Lorazepam. CNA 1 text would then mean please hide my Lorazepam. CNA 1 would be indicating ownership of the Lorazepam.</p> <p>A review on 7/2/19 of the document entitled #goodnight [REDACTED] Text Exchange indicated the following text exchange between LVN 1 and CNA 1 on 1/17/18 at 12:26 PM through 3:06 PM: *Brother LVN 1 please look out when they do</p>	F 605		
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F 605	<p>Continued From page 36</p> <p>draw lots ...-CNA 1</p> <p>*Yes I'll watch like martial law-LVN 1</p> <p>*If CNA 8 is working this afternoon I would rather have him have Resident 11-LVN 1</p> <p>*Everybody are hoping for draw lots. If we don't do the draw lots they will raise questions. [Unidentifiable Person] will get mad if the draw lots will not happen-CNA 1</p> <p>*Lol-CNA 1</p> <p>*ok-LVN 1</p> <p>*What if you pick Resident 11-LVN 1</p> <p>*it's ok-CNA 1</p> <p>*Picture of a hand holding a bag of medications which included Methadone, Tramadol, and multiple other medications. -LVN 1</p> <p>*#mercurydrugs-LVN 1</p> <p>*#anggamotaylagingbago-LVN 1</p> <p>*#goodnightResident11-LVN 1</p> <p>*Hahahaha ...I don't have to say it ...Im glad you are there-CNA 1</p> <p>*Lol-CNA 1</p> <p>*A lot-CNA 1</p> <p>*Hahahaha-LVN 1</p> <p>The above indicated that Resident 11 was a difficult Resident. Drawing lots referred to a random drawing as to which CNA would take care of certain residents. LVN 1 asks if CNA 1 "What if you pick Resident 11" and then sends the texts messages a picture of a zip-lock bag of sedating medications, #mercurydrugs, #anggamotaylagingbago, and #goodnightResident11. Mercury drugs is a drugstore which uses the slogan "ang gamut ay laging bago" assures the freshness of its product inventory. The hashtag texts would then mean Resident 11 would get fresh drugs to put him to sleep. Then CNA 1 says how glad he is that LVN 1 was there and then laughs.</p>	F 605		
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F 605	<p>Continued From page 37</p> <p>An observation on 7/3/19 of the text picture of the bag of medications texted, the text exchange dated 1/17/18 mentioned above, from LVN 1 to CNA 1 revealed multiple medications in a worn zip lock bag that was held up by LVN 1s left hand (facility confirmed it was LVN 1s left hand). There was a syringe where a date was partially visible 2/21. There was a unit dose package clearly labeled Tramadol 50 mg tablet. During an interview on 7/3/19 at 3:00 PM the DOP stated that the medications in the bag were clearly from Laguna Honda Hospital. The DOP also stated that the syringe dated 2/21 was Methadone Liquid Suspension and the Tramadol 50 mg tablet was Tramadol. She said that the other medications were most likely Morphine, Clonazepam, and Oxycodone. She also confirmed that, the medications that drugged Resident 2, Resident 6, Resident 11, Resident 24, and Resident 25, were all found in the bag held by LVN 1 with the exception of Quetapine, Gabapentin and Mirtazapine. She said it was possible those drugs were in the bag too but could not be clearly seen in the picture.</p> <p>An immediate jeopardy (IJ) was declared on 7/11/19 at 3:40 PM in the presence of the Acting Chief Executive Officer (CEO), Acting Director of Quality, Chief Nursing Officer (CNO), Quality Nursing Manager, and a Quality Nurse when five of 29 residents received medications not prescribed by their physicians that resulted in five residents having life-threatening complications resulting in a significant decline in their physical functioning.</p> <p>The IJ was lifted on 7/12/19 at 6:36 PM after the</p>	F 605		

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F 605	Continued From page 38 facility presented an acceptable Plan of Correction (POC) and the survey team verified the implementation of the POC. The facility staff present were Acting CEO, Director of Quality from GACH 2, CNO, Quality Nursing Manager, and a Quality Nurse.	F 605		
F 607 SS=L	<p>Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement its abuse prevention and reporting policy and procedure when 21 of 29 sampled residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, and 14, 18, 19, 20, 21, 22, 24, and 25) where subjected to physical, verbal, and or mental abuse by staff members. When:</p> <ol style="list-style-type: none"> <li>1. The facility did not identify incidents of abuse</li> <li>2. The facility failed to report incidents of abuse in a timely manner to California Department of Public Health (the Department) and responsible party (RP, person with authority to make decisions for another).</li> </ol>	F 607		

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F 607	<p>Continued From page 39</p> <p>3. The facility failed to train staff as mandated reporters to report incidents of abuse directly and within two hours to the Department, the Ombudsman, and local law enforcement.</p> <p>Failure to develop and implement written abuse protection policies and procedures may lead to residents harm by not ensuring the protections for their health, welfare and rights. Failure to report reasonable suspicions of a crime against residents within prescribed timeframes to law enforcement agencies, is a potential risk for physical and psychosocial residents harm by not ensuring their safety and well-being.</p> <p>Findings:</p> <p>Review of the document titled "Complaint/Incident Intake Report" indicated the facility left a voicemail (recorded message) on 2/6/19 at 5:45 PM that videos and pictures of "naked" residents had been taken and exchanged among 3 staff members (certified nursing assistant 1 [CNA 1], CNA 2 and licensed vocational nurse 1 [LVN 1]), on their personal cellular phones. The facility identified the residents that appeared in the videos and photographs and provided the Department copies of the photographs and a digitally encrypted file of the videos. The videos depicted residents being verbally provoked and humiliated, and engaged in sexually explicit conversations with staff members.</p> <p>Identification:</p> <p>1. Review of the clinical record for Resident 14, indicated Resident 14 was admitted 09/29/15 with diagnoses of traumatic brain injury, seizures, left hemiplegia (Muscle weakness or partial paralysis</p>	F 607		

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F 607	<p>Continued From page 40</p> <p>on one side of the body that can affect the arms, legs, and facial muscles). Review of the most recent comprehensive Minimum Data Set (MDS, an assessment tool), dated 5/9/19 indicated he was dependent on staff assistance for activities of daily living like mobility, transferring from and to bed, dressing, eating, personal hygiene, bathing; and fully dependent on staff for toileting. The brief interview for mental status (BIMS, a short scanner to help detect cognitive (intellectual activity such as thinking, reasoning, remembering) impairments (loss of function) indicated a score of 10 (maximum score of 15 with 13 to 15 no cognitive defects, 8 to 12 mild cognitive defect, 0 to 7 severe cognitive defect).</p> <p>Review of digitally encrypted files, provided by the facility, with photos, videos and text messages from the personal cellular phones of LVN 1, CNA 1, and CNA 2, included two undated short video segments of Resident 14 lying in bed covered with a blanket, eyeglasses on and fully awake. CNA 2 is heard agitating Resident 14 to get a response and making derogatory statements. CNA 2 is heard on the video asking Resident 14 "what does the [redacted] mean...?", in reference to the resident's last name initial letter. Resident 14 answered by giving his full name, followed by CNA 2 stating "I thought it meant [redacted] ..." (a slur in Spanish for a gay man). The videos also showed CNA 2 asking Resident 14, four times, if he wanted a towel to wipe "the cum off ...". These statements by CNA 2 provoked an immediate strong emotionally angry response from Resident 14 exhibited by Resident 14 screaming profanities in both English and Spanish and moving his hands.</p> <p>During an interview with the Nurse Manager (NM</p>	F 607		

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NAME OF PROVIDER OR SUPPLIER  <b>LAGUNA HONDA HOSPITAL &amp; REHABILITATION CTR D/P SNF</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>375 LAGUNA HONDA BLVD.</b> <b>SAN FRANCISCO, CA 94116</b>		
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F 607	<p>Continued From page 41</p> <p>1) on 6/10/19 10:20 AM, he stated " There were two videos of Resident 14 taken by CNA 2. In the first week of May [2019], I saw a video in which a Patient Care Assistant ( CNA 2) is seen going inside Resident 14's room, CNA 2 ... said some things in a different language, not nice words from CNA 2, abusive words...provoking him to say things...Resident 14 became angry, yelling to CNA 2 to get out of his room...A second video showed CNA 2 ...offering Resident 14 a towel and asking him if he wanted to wipe his cum off...Resident 14 became angry yelling in English and Spanish..." NM 1 did not elaborate when asked on more specifics of contents of words used by CNA 2. When asked about the videos, NM 1 stated "They were on staff's cell phones...The only reason these incidents came out is because a staff member complained to me of sexual harassment from another staff member...and these [the videos] were found...Yes, all staff is trained annually for abuse prevention and reporting; the staff members involved with the videos and photos of residents did not report the incidents..."</p> <p>During an interview with Resident 14 on 6/10/19 1:30 PM, while he was awake and lying down in bed, with a lunch tray placed on an over the bed table in front of him, when asked about how things were going, he stated "Terrible...staff never pays attention...they are unprofessional, they do not behave like CNAs or nurses...". Resident 14 was oriented to day of the week and place, ("Monday, [Facility Name]"), regarding month he said "June or July" and about year "2018 or 2019".</p> <p>During a 6/10/19 1:45 PM interview with Resident 14, when asked about any specific information</p>	F 607		

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F 607	<p>Continued From page 42</p> <p>about his previous comments around staff, he stated " I don't want to talk about bad stuff...I barely remember what happened..."</p> <p>During an interview with the Chief Executive Officer (CEO), the Director of Nursing (DON), the Quality Management Director (DQM), and a City Attorney (CA); on 6/19/19 12:30 PM; DON and DQM acknowledged the video recordings found on CNA 2 and LVN 1 cell phones showed Resident 14 was "...abused by CNA 2 ...". DON stated "...yes, some of the incidents are possibly a crime against residents, we reported them to law enforcement when we became aware...". CEO stated "...I wish all of these [incidents] were reported in 2016 when some of the Residents pictures were taken...we are failing at reporting...If we had a safety culture, reporting would have happened three years ago...". DQM stated "...It has been mind blowing these incidents happened...we did not see any signs..."</p> <p>During an phone interview with Resident 14's RP on 6/25/19 4 PM, the RP stated "The very first contact I had with the facility was through a letter dated 4/10/19 and I was confused because the subject matter was about data breach...abuse was not mentioned, the letter made reference to something discovered on 3/20/19 regarding staff recording and sharing through personal cell phones...it was until 4/19/19 I spoke with the Director of Nursing (DON) when she told me an investigation was taking place, she referred to staff misconduct..."</p> <p>2. Review of clinical record for Resident 13 indicated Resident 13 was admitted 10/10/08 with diagnosis that included anoxic encephalopathy (condition resulting from brain being deprived of</p>	F 607		

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F 607	<p>Continued From page 43</p> <p>oxygen) resulting in cognitive impairment with mental capacity of a seven-year-old. Review of the MDS dated 1/18/19, indicated, Resident 13 had a BIMS score of 12 which indicated, moderate cognitive defect.</p> <p>Review of digitally encrypted files, provided by the facility, with photos, videos and text messages from the personal cellular phones of LVN 1, CNA 1, and CNA 2 included one video dated 1/8/16 at 9:32 AM of Resident 13 lying in bed. The video showed Resident 13 lying on his side in bed and suddenly being kicked on the buttocks by a staff member (the only thing seen of the staff member was the leg and foot wearing a black boot), causing the resident to jerk.</p> <p>During an interview with Director of Quality Management (DQM), on 5/31/19 at 10:30 AM, DQM stated "This is substantiated as physical abuse (referring to Resident 13 being kicked) ... it definitely happened."</p> <p>Review of communication titled "Subject: Notice of Data Breach" dated 4/10/19 addressed to Resident 13 indicated "...staff member took photographs...without her consent and shared the photographs with another staff member using their personal cell phones..."</p> <p>3. Review of the clinical record for Resident 12 indicated Resident 12 was admitted 6/5/17 with diagnosis of schizoaffective disorder (mood disorder such as mania and depression). Review of the MDS dated 9/18/17 indicated a BIMS score of 15 no cognitive defect.</p> <p>Review of digitally encrypted files, provided by the facility, with photos, videos and text messages</p>	F 607		

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F 607	<p>Continued From page 44</p> <p>from the personal cellular phones of CNA 1 and CNA 2 included two videos dated 8/5/17 at 9:36 AM and 9:39 AM that showed Resident 12 engaged in sexually explicit dialogue with staff.</p> <p>During an interview with Director of Quality Management (DQM), on 5/31/19 at 10:30 AM, DQM stated, "This is substantiated as abuse."</p> <p>Review of untitled and unsigned document provided by DQM dated 5/24/19 at 3 PM, indicated on "2/28/19 at 4:45 PM the RP for Resident 12 was notified by DON by telephone and informed the RP of the potential abuse allegation reported on 2/6/19".</p> <p>Review of the clinical record for Resident 4 indicated Resident 4 was admitted 5/24/16 with diagnosis of stroke (CVA, blood supply to part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients). Review of the MDS dated 12/13/19 indicated a BIMS score of 15.</p> <p>Review of digitally encrypted files, provided by the facility, with photos, videos and text messages from the personal cellular phones of CNA 1 and CNA 2 included six videos that showed Resident 4 being directed to use inappropriate language. Four of the six videos dated 8/3/18 from 7:15 PM to 8:10 PM showed Resident 4 being questioned by CNA 1 on sexual practices. A fifth video dated 8/4/18 at 7:42 PM showed Resident 4 being prompted to sexually explicit remarks. A sixth video dated 8/3/18 at 8:54 PM showed staff borrowing money from Resident 4.</p> <p>Review of communication titled "Subject: Notice of Data Breach" dated 2/27/19 addressed</p>	F 607			

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F 607	<p>Continued From page 45</p> <p>Resident 4 indicated "...staff member took photographs...without her consent and shared the photographs with another staff member using their personal cell phones..."</p> <p>4. Review of the clinical record for Resident 10 indicated Resident 10 was admitted 1/23/19 with diagnosis of cellulitis (potentially serious bacterial skin infection). Review of the MDS dated 2/6/19 indicated a BIMS score of 15.</p> <p>Review of digitally encrypted files, provided by the facility, with photos, videos and text messages from the personal cellular phones of CNA 1 and CNA 2 included one photograph dated 7/27/18 at 11:34 AM that showed Resident 10 lying in bed. In the photograph Resident 10 was lying on his side with his buttocks exposed, his face was not visible. In the photograph a caregiver's hand can be seen administering a "Fleet's enema" (a saline laxative that cause an immediate bowel movement) to the Resident.</p> <p>During an interview with Director of Nursing (DON) and DQM on 5/31/19 at 10:30 AM, DON stated, that nude photography of residents without consent is sexual abuse. DQM stated "This is substantiated as sexual abuse because there is nudity."</p> <p>5. Review of the clinical record for Resident 3 indicated Resident 3 was admitted 12/24/15 with diagnosis of hyponatremia (low sodium blood levels). MDS dated 12/3/18 indicated Resident 3 cognitive skills for daily decision making was moderately impaired.</p> <p>Review of digitally encrypted files, provided by the</p>	F 607		
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F 607	<p>Continued From page 46</p> <p>facility, with photos, videos and text messages from the personal cellular phones of LVN 3 and CNA 1 included a photograph of Resident 3 dated 4/3/18 at 1:09 PM. The photograph showed Resident 3 with a white towel tied around her mouth. In the photograph a blue tourniquet (a device which applies pressure to an extremity to limit -the flow of blood) can be seen wrapped around her left upper arm.</p> <p>During an interview with the Chief Executive Officer (CEO), on 6/5/19, at 2:00 PM, in her office, CEO stated "... Resident 3 was identified in two photographs... one of which was, being restraint by the hands of staff, with a white cloth towel around the face covering the mouth, while the eyes and upper face are grimacing A tourniquet wrap around the left upper arm, might be happening because of an intravenous insertion (a small plastic tube, inserted into a vein)...This is not acceptable practice..."</p> <p>Review of communication titled "Subject: Notice of Data Breach" dated 2/27/19 addressed to RP of Resident 3 indicated "...staff member took photographs...without her consent and shared the photographs with another staff member using their personal cell phones..."</p> <p>6. Review of the clinical record for Resident 1 indicated Resident 1 was admitted 5/9/18 with diagnosis status post laminectomy (surgical procedure that removes a portion of the vertebral bone). Review of the MDS dated 11/19/18 indicated a BIMS of 3 indicating severe cognitive defect.</p> <p>Review of digitally encrypted files, provided by the facility, with photos, videos and text messages</p>	F 607		
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F 607	<p>Continued From page 47</p> <p>from the personal cellular phones of LVN 1 and CNA 1 included a photograph of dated 7/3/18 at 4:37 PM of Resident 1 lying in bed. The photograph showed Resident 1 lying on his side with his buttocks and genitals exposed during perineal care with three unidentified staff members present.</p> <p>During an interview with the DON on 5/29/19 at 2:30 pm, DON stated, that nude photography of residents without consent is sexual abuse.</p> <p>Reporting:</p> <p>During an interview with Unit North 1-day shift registered nurse 1 (RN 1), on 6/4/19 1:30 PM, RN 1 stated if he witnessed abuse, "I will inform the Nurse Manager...If it is determined it was abuse, notify the State..."</p> <p>During an interview with CNA 4 on 6/4/19 2:15 PM, CNA 4 stated if she witnessed abuse, "I will inform the charge nurse, the Nurse Manager..."</p> <p>During a concurrent interview with an Environmental Services Staff (EVS 1) and Director of EVS (DEVS) on 6/4/19 2:45 PM, EVS 1 stated if she witnessed abuse, "I will inform my supervisor, the charge nurse...call the Ombudsman..."</p> <p>During an interview with the Unit Coordinator (UC) on 6/4/19 3:15 PM, UC stated if she witnessed abuse, "I will report to my charge nurse..."</p> <p>During an interview with the evening shift RN 2 on 6/4/19 3:35 PM, RN 2 stated, if she witnessed abuse, "I will talk with my supervisor..."</p>	F 607			

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F 607	<p>Continued From page 48</p> <p>During an interview with the Nurse Manager (NM 1) on 6/10/19 10:20 AM, he stated, "...all staff is trained annually for abuse prevention and reporting; the staff members involved with the videos and photos of residents did not report the incidents..."</p> <p>During an interview with the CEO and DQM on 6/19/19 12:30 PM, CEO stated "...I wish all of these [incidents] were reported in 2016 when some of the Residents pictures were taken...we are failing at reporting...If we had a safety culture, reporting would have happened three years ago...". DQM stated "...It has been mind blowing these incidents happened...we did not see any signs...".</p> <p>Training:</p> <p>Record review of staff "Read and Sign" for "Residents Rights &amp; Abuse Prevention (Preservation of Dignity, Including Provision of Dignity and Abuse Prevention) - Live Class for CNAs/PCAs/HHAs" didactic material for the week of 4/2/18 to 4/6/18, included signatures from all CNAs, PCA, and HHAs who attended the class including CNA 2 and CNA 1.</p> <p>Record review of staff "Read and Sign" for "Prevention, Investigation, &amp; Reporting of Abuse and Accidents" didactic material for the week of 9/4/18 to 9/12/18 indicated signature from all staff who attended the class including CNA 2 and CNA 1, LVN 1, LVN 3.</p> <p>Review of document from the facility Department of education and Training titled "...Reporting, Assessment, Documentation, and Identification /</p>	F 607		

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F 607	<p>Continued From page 49</p> <p>Recognition of Potential Abuse" dated 2/2019 indicated "...Reporting Guidelines...Whom to report abuse allegations: Every employee (mandated reported) should report abuse allegations to their manager / supervisor immediately...Who will report to CDPH: QM Nurse during business hours. Nursing Operations manager or Supervisor after business hours (including weekends and holidays) ..."</p> <p>The facility policy and procedure titled "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response" dated September 11, 2018 indicated: "[Facility name] shall promote an environment that enhances resident well-being and protects residents from abuse...Policy 1. employees ...shall strive to protect residents from physical, psychological, fiduciary and verbal abuse and neglect...Purpose: 1. To protect the resident from abuse...2. To report incidents of alleged violations of abuse...5. To meet reporting requirements as mandated by federal and state laws and regulations...Education...b. Employees are obliged to report any reasonable suspicion of abuse against a resident to a law enforcement agency...</p> <p>Reporting. a. The facility mandates staff to report suspected abuse to the local Ombudsman...</p> <p>b. The facility also requires employee, manager, agent or contractor ...to report to the...Sheriff ' s Department any reasonable suspicion of a crime committed against a resident of [Facility Name] ...</p> <p>c. The nurse manager, charge nurse, and nursing supervisor shall communicate to inform one another of the alleged abuse.... ..ii. Immediately</p>	F 607		

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F 607	<p>Continued From page 50</p> <p>inform the resident and /or surrogate decision maker that the abuse allegation is being taken seriously; identify for the resident and/or surrogate decision maker the steps being taken to provide for the resident's safety; and assure the resident and/or the surrogate decision maker that an investigation is being conducted...</p> <p>i. This policy designates the Director of QM [Quality Management] as the primary mandated reporter for [facility name] ...The Director of QM or designee ensures that allegations of resident abuse are reported to the Ombudsman, Sheriff ' s Department, and CDPH..."</p> <p>Review of "The California Welfare and Institute Code 15630 (a)" indicated "Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."</p> <p>Review of "The Federal Elder Justice Act" indicated "All instances of suspected crimes committed against residents or others receiving care in long term care health facilities (skilled nursing facilities) receiving at least \$10,000 per year in Medicare / Medicaid funds, must be reported, by the facility, to at least one local law enforcement agency and to the Licensing and Certification Program of the California Department of Public Health..."</p>	F 607			

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F 607	Continued From page 51  An immediate jeopardy (IJ) was declared on 7/11/19 at 3:40 PM in the presence of the Acting Chief Executive Officer (CEO), Acting Director of Quality, Chief Nursing Officer (CNO), Quality Nursing Manager, and a Quality Nurse for the facility's failure to protect 21 of 29 sampled residents from physical, mental verbal, and sexual abuse and chemical and physical restraints when:  a. The facility did not identify incidents of abuse b. The facility failed to report incidents of abuse in a timely manner to the California Department of Public Health (The Department) and the responsible parties, and c. The facility failed to train staff as mandated reporters to report incidents of abuse directly and within 2 hours to the Department, the Ombudsman, and local law enforcement.  The IJ was lifted on 7/12/19 at 6:36 PM after the facility presented an acceptable Plan of Correction (POC) and the survey team verified the implementation of the POC. The facility staff present were Acting CEO, Director of Quality from GACH 2, CNO, Quality Nursing Manager, and a Quality Nurse.	F 607			
F 689 SS=H	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent	F 689			

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F 689	<p>Continued From page 52</p> <p>accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to ensure the safety for four of four sampled residents (Residents 26, 27, 28, and 29) by not monitoring/supervising effectively when:</p> <p>Three residents had positive urine toxicology for illicit drugs identified as contraband (illegal) on:</p> <p>a) 5/30/19 - Resident 26 - sent to the emergency room - urine positive for benzodiazepine</p> <p>b) 5/19/19 - Resident 27 - urine toxicology positive for morphine and codeine</p> <p>c) 5/29/19 - Resident 28 - sent to emergency room - urine tested positive for benzodiazepine and methamphetamine</p> <p>When facility failed to provide adequate supervision to one resident (Resident 29).</p> <p>d) Resident 29 hit head on equipment while being transferred using a mechanical lift.</p> <p>As defined by the dictionary: "Illicit drugs - the first category of illicit drugs includes those drugs that are illegal to manufacture, sell, purchase and consume. Drugs that fall into this category are taken solely for recreational purposes and include cocaine, heroin, methamphetamine, MDMA, hashish, opium, PCP, ..." Illicit drugs are highly addictive and pose serious risks. "Contraband - "goods that have been imported or exported illegally...."</p> <p>This deficient practice caused physical harm to residents.</p> <p>Findings:</p>	F 689			

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F 689	<p>Continued From page 53</p> <p>The BIMS (Brief Interview for Mental Status), is most often used as part of an assessment tool called the Minimum Data Set (MDS) in nursing homes. The BIMS is conducted periodically to assess cognition over time.</p> <p>The total possible BIMS score ranges from 00 to 15. 13 - 15: cognitively intact 028 - 12: moderately impaired ...</p> <p>During an observation on 6/4/19, from 10:00 AM to 3:00 PM, 3 units (North 1, North 2, and Pavilion Mezzanine) with Risk Manager 1, the log titled "Resident Sign In and Sign Out Sheet" indicated the "Date, Name, Time Left, Place Going To, and Time Return". This log was used for anyone who entered or left the units.</p> <p>During separate interviews with Nurse Manager (NM) 1 on 6/4/19, at 2:00 PM and NM 4 on 6/4/19, at 2:30 PM, both stated that "when residents return from "out on pass", they are physically assessed for any obvious physical injuries or behavioral changes. Clinical search (the search of a resident's room, personal belongings and any packages or property brought by visitors) is not done when there are no obvious physical or/and behavioral changes."</p> <p>During an interview with Risk Manager (RM) 1 on 6/5/19, at 11:00 AM, RM 1 stated that this concern (bringing contraband into the facility) will be considered. And the policy and procedure on "Clinical Search Protocol" and "Leave of Absence Out On Pass" will be reviewed.</p> <p>a) During an observation on 6/4/19, at 10:30 AM, in the Pavilion Mezzanine unit with RM 1, Resident 26 was observed from a distance, comfortably seated in a wheelchair. Resident 26</p>	F 689			

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F 689	<p>Continued From page 54 refused to be interviewed.</p> <p>During an interview with NM 4, 26/4/19, at 10:40 AM, in the Pavilion Mezzanine unit, NM 4 confirmed that Resident 26, refused to inform anyone how, when, what drug, and who gave him the illicit drug.</p> <p>During review of the clinical record for Resident 26, the form titled "History and Physical" dated 5/21/19 indicated "... date of admission 5/13/19 - 60-year-old ... IV drug use with heroin, current cocaine use ... underwent mitral valve replacement from another hospital ..."</p> <p>The form titled "Progress Notes (Nurses)" dated 5/29/19 3:04 PM indicated "...Resident appears lethargic and still noted confuse ... transferred to Emergency Room (ER) ..."</p> <p>The form titled "Progress Notes (Nurses)" dated 5/29/19 9:23 PM indicated "...Urine tox screen with positive Benzo and resident reused comprehensive urine tox screen ..."</p> <p>The form titled "Progress Notes (Nurses)" dated 5/30/19 12:55 PM indicated "...Resident was informed that his urine test was positive for benzo which are not prescribed, and not a part of his ordered meds. Resident declined to discuss this further and provide information regarding how this med was obtained. ...Urine Drug Screen (Lab result from 5/29/19) ...Benzodiazep/Metab - Positive, unconfirmed ..."</p> <p>The MDS dated 6/6/19, indicated "... BIMS Summary Score 15 (13-15 cognitively intact).</p> <p>b) During an attempted observation on 6/5/19, at 1:00 PM with RM 2, in North 2 unit, Resident 27 refused to be interviewed when asked.</p>	F 689			

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F 689	<p>Continued From page 55</p> <p>During an interview with NM 5 on 6/5/19, at 1:10 PM, NM 5 stated that Resident 27 would not disclose who supplied him the illicit drug he took on 5/19/19. NM 5 added that Resident 27 stays in the smoking area.</p> <p>During a review of the clinical records for Resident 27, the form titled "Progress Notes (Nurses)" dated 5/19/19 10:02 PM indicated "Resident vomited thick whitish/brownish colored emesis ...According to on call MD, no plan to transfer out resident at this time. He ordered stat labs, urine toxicology .... Called PM acute nurse to draw blood ...."</p> <p>The form titled "Progress Notes (Nurses)" dated 5/21/19 03:42 PM indicated "Resident utox result came and noted positive for 6 monoacetylmopine, morphine, 11 nor 9 carboxy thc, codeine, among others. Resident approached by this writer and nurse manager about said results and residents denies on using drugs but admits to using weed.... "</p> <p>Review of document titled "Investigation of Alleged Abuse" dated 5/19/19 at 2000 (8 PM) indicated "... Conclusion Resident 27 is his own decision maker with history of heroin abuse.... Resident 27 is fully aware of his actions; he is aware that the laced weed he shares with his friends can be tied up with any other illicit drugs. This is justified by him saying to this writer they mix everything down there...."</p> <p>The MDS dated 05/29/19, indicated"... BIMS Summary Score 15 (13-15 cognitively intact).</p> <p>c) During review of clinical records for Resident 28 the document titled "Investigation of Alleged</p>	F 689			

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F 689	<p>Continued From page 56</p> <p>Abuse" dated 5/30/19 indicated "... Conclusion (dated 6/4/19) ... per tox results, resident was positive for benzo and amphetamines which are not prescribed to any residents in the facility. 44-year-old with history of PTSD, depression, substance use disorder (drugs of choice are: benzo, and meth), he is AO X 4, and his own decision maker.... reports buying Xanax (a drug used to treat anxiety) from resident ...."</p> <p>The form titled "Progress Notes (Nurses)" dated 5/30/19 28:59 AM indicated Resident 28 '...was up in the wheelchair and RN noted 5 white oblong tablets (Xanax 2 mg. verified with the pharmacy) at his bedside. Resident was not completely alert when MD was doing a neurocheck assessment with him. He said that this medication was bought from resident. He has been sleeping and been up in the wheelchair for longer hours. .... resident was responsible party for himself and he has already accepted in to hospital by ambulance ...ambulance around 10 AM ..."</p> <p>During an observation on 6/4/19, at 9:00 AM, in the dining room of the Pavilion Mezzanine unit, Resident 28 was seated on a wheelchair, alert, responsive, and pleasant. When asked if he minds being asked about the incident that happened to him on 5/30/19, he did not hesitate. He stated that he got the drug from another resident who goes out on pass. He did not reveal the name of the resident involve.</p> <p>During an interview on 6/4/19, at 9:30 AM, with NM 4, NM 4 stated that Resident 28 was independent and goes wherever he pleases within the facility compound.</p> <p>Review of the MDS dated 6/4/19, indicated</p>	F 689			

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F 689	<p>Continued From page 57</p> <p>Resident 28 BIMS Summary Score - 15 (13-15 cognitively intact),</p> <p>d) Clinical record for Resident 29 dated 2/11/19, indicated Resident 29 was a wheelchair dependent resident admitted with diagnosis of amyotrophic lateral sclerosis (ALS, a condition that causes weakness and loss of muscle bulk).</p> <p>During a review of clinical records for Resident 29, MDS, dated 2/17/19, indicated a BIMS score of 15 no cognitive impairment. The functional assessment indicated Resident 29 required two or more care givers for transfer and mobility.</p> <p>During an observation and concurrent interview with Resident 29 on 26/5/19, at 1:42 PM, Resident 29 was seated in wheelchair by side of bed. Resident 29 stated, "...certified nursing assistant 5 (CNA 5) did not transfer me right." Resident 29 then stated my hair got stuck in the "sling" (a cable, chain, rope or webbing used with a lift to transfer a person). "I asked CNA 5 to stop but CNA 5 didn't stop."</p> <p>During an interview with CNA 5, on 26/12/19, at 3:33 PM, CNA 5 stated, on 5/26/19, "...nobody was around to help so I transferred Resident 29 by myself."</p> <p>During an interview with CNA 6, on 26/12/19, at 4:12 PM, CNA 6 stated, on 5/26/19, "...Resident 29 was already in bed when I got to the room..." CNA 6 stated her duties included helping staff transfer residents.</p> <p>During an interview with registered nurse (RN) 1, on 6/5/19, at 2:00 PM, RN 1 stated, Resident 29</p>	F 689			

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F 689	<p>Continued From page 58</p> <p>reported the incident that occurred on 5/26/19 at 5:30 pm on 5/28/19. RN 1 further stated that Resident 29 should have been transferred with two staff members.</p> <p>During a review of the clinical record for Resident 29 dated 5/28/19 the Nurse's Notes indicated "... Resident 29 complained that her "head was hanging" during the transfer from wheelchair to bed. The Progress Note dated 5/28/19 entered by MD 1 indicated Resident 29 "...felt discomfort at right lower temporal bone area...".</p> <p>The facility policy and procedure titled "Unusual Occurrences" revised November 13, 2018 "... An Unusual Occurrence is determined as an event or condition, which has had or may have an adverse effect on the health or safety of a resident, visitor, volunteer, staff or student. .... Purpose: The Purpose of the Unusual Occurrence system is to identify those events or conditions and institute corrective action that will address immediate needs and prevent similar future incidences.....The performance Improvement and Patient Safety Committee (PIPS) a committee of the Medical Staff, is responsible for reviewing and evaluation Unusual Occurrence Reports .....A unique log number shall be assigned to each submitted UO, Risk Management Nurse shall triage UOs within 24 hours or the next business day and request for follow-up information as necessary using the on-line UO system ....The Risk Management Nurse shall assure that the required follow-up letter is sent and a copy placed in the CDPH file....QM staff shall aggregate UO data to identify patterns/trends....."</p> <p>The facility policy and procedure titled "Leave of</p>	F 689		

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F 689	<p>Continued From page 59</p> <p>Absence (Out on Pass) revised May 14, 2019, Purpose: To protect the health and safety of the residents ...did not address comprehensively address when residents on returning from pass.... Procedure: 1. Notification of Pass Policy - ... shall provide each newly admitted residents ... with information's regarding the pass policy. ...2. Request for a Pass and the Pass Order Form - ...3. ...Census Management - ... 4. Compliance/Adherence with Pass Privilege - When leaving on pass and on returning from pass, residents shall check in and out with the nursing staff on the care unit. ..."</p> <p>The facility policy and procedure titled "Clinical Search Protocol revised March 12, 2019, Policy ...shall act to ensure the safety of residents and staff, and to provide necessary care for each residents to attain or maintain their highest practicable physical, mental, and psychological well-being. ...</p> <p>Definition: Contraband - Illegal or prohibited items, such as dangerous objects, prohibited drugs and drug paraphernalia, alcohol, and smoking or tobacco paraphernalia. Illicit or illegal drug - A drug or substance that cannot be obtained legally or by prescription, or any substance prohibited by code or statute... Procedure - ... e. Residents who return from pass privileges may be asked to empty their pockets and their packages may be searched if contraband is reasonably suspected...."</p> <p>The facility policy and procedure titled "Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response revised 9/11/18, ... Reporting sheets completed by staff to internally report the incident (i.e. Incident or Unusual Occurrence Reports which are</p>	F 689			

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F 689	Continued From page 60 confidential reports under Section 11527 Code), as well as reporting documents such as Preliminary Investigation forms as evidence of appropriate reporting to the State survey agency...."  The facility policy and procedure titled, "Battery-Operated Ceiling Lift ", dated March 12, 2019, indicated "... Policy:2. Two nursing staff members are always required for operation of the Battery Operated Ceiling Lift (a mechanical device used to carry a person)."	F 689			

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