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

PRINTED: 11/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056258	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY HEALTHCARE & WELLNESS CENTRE, LP	2490 COURT STREET REDDING, CA 96001

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Recertification Survey conducted from November 4, 2024 to November 7, 2024. The facility was found to be not in compliance with 42 CFR 483.5-483.75 - Subpart B - Requirements for Long Term Care Facilities. The facility census was 100. Sample size: 30	F 000	"see attached"	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580	CA DEPT OF PUBLIC HEALTH CHCQ Field Operations North Division- Chico Received Date: 12/03/2024 Compliance Date: 12/5/24 Approved Date: 12/5/24 Approved By: Joanna Mulcahy, HFES	

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

12/02/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to notify the physician when a medication was not available for administration for 1 (Resident #58) of 6 residents reviewed for unnecessary medications. Findings included: A facility policy titled, "Medication Orders," dated 04/2008, specified, "The prescriber is contacted for direction when the medication will not be available."	F 580		

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F 580	Continued From page 2 An "Admission Record" indicated the facility admitted Resident #58 on 08/17/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of bipolar disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/27/2024, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #58's care plan included a focus area initiated 05/31/2023 that indicated the resident used psychotropic medications related to bipolar disorder. Interventions directed staff to administer psychotropic medications as ordered by the physician and monitor for side effects and effectiveness every shift. Resident #58's September 2024 "Medication Administration Record [MAR]" revealed a transcription of an order for Depakote tablet delayed release 250 milligrams (mg) with instructions to give 250 mg by mouth at bedtime for bipolar disorder. The MAR revealed that on 09/29/2024 and 09/30/2024 Depakote was coded "9" (other/see progress notes). Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 09/29/2024 that indicated the resident's Depakote was not available in the facility. An Orders-Administration Note dated 09/30/2024 indicated the resident's Depakote was reordered and was not available in the facility. Resident #58's October 2024 MAR revealed a transcription of an order for Depakote tablet	F 580		

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F 580	Continued From page 3 delayed release 250 mg with instructions to give 250 mg by mouth at bedtime for bipolar disorder. The MAR revealed that on 10/07/2024, 10/08/2024, 10/10/2024, and 10/12/2024 through 10/17/2024 Depakote was coded "9" (other/see progress notes). Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/07/2024 and 10/08/2024 that indicated the resident's Depakote was not available in the facility. Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/10/2024 that indicated the resident's Depakote was reordered and had not been received. Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/12/2024 that indicated the resident's Depakote was reordered. Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/13/2024 that indicated they were waiting on delivery of the resident's Depakote from the pharmacy. Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/14/2024 that indicated the resident's Depakote had not been received. Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/15/2024 that indicated the Depakote was unavailable. Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/16/2024 that indicated they were waiting for delivery of the	F 580		

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F 580	Continued From page 4 resident's Depakote. Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/17/2024 that indicated the resident's Depakote had not been received. Resident #58's "Progress Notes" for the timeframe from 09/29/2024 through 10/17/2024 revealed no evidence that staff contacted the physician about the resident's Depakote not being available from the pharmacy and not being administered. During an interview on 11/06/2024 at 2:52 PM, Licensed Vocational Nurse (LVN) #2 stated if a medication were not available during the medication pass, she would fax the physician and let him know. She stated the faxes should be kept in the resident's medical record. LVN #2 stated she did not recall if she notified the physician about Resident #58's Depakote not being available but stated if she did, she would have sent him a fax and those were kept in medical records. During an interview on 11/06/2024 at 3:03 PM, LVN #3 stated she would fax the physician to notify him if a resident's medications were not available from the pharmacy to administer, and the fax should be kept in the resident's medical record. During an interview on 11/07/2024 at 11:01 AM, LVN #4 stated if a resident missed a dose of medication, she would call the physician and the responsible party, and it should be documented in a progress note.	F 580		

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F 580	Continued From page 5	F 580		

During an interview on 11/07/2024 at 11:05 AM, LVN #5 stated the physician should be notified any time a resident missed a dose of medication, and if it were due to not being available from the pharmacy, she would get an order to administer the medication when it arrived from the facility.

During an interview on 11/07/2024 at 11:07 AM, LVN #6 stated if a medication was not available from the pharmacy to administer, they should call the physician and let them know, document it in a progress note, and place the resident on alert charting. She stated in Resident #58's situation, the pharmacy, physician, and the Director of Nursing (DON) should have been called, and the resident should not have gone that many days without the medication.

During an interview on 11/07/2024 at 11:31 AM, the Medical Records Supervisor stated they did not have any faxes to the physician regarding Resident #58's Depakote not being available.

During an interview on 11/07/2024 at 11:54 AM, the Medical Director stated he would get over 50 faxes a day and did not recall receiving information that Resident #58 did not receive their Depakote.

During an interview on 11/07/2024 at 1:11 PM, the DON stated if the nurse was not able to receive and administer a medication by the end of their shift, then they should let the physician know. She stated she was not aware of Resident #58's Depakote not being available. She stated the physician should have been notified and it should have been documented.

During an interview on 11/07/2024 at 1:50 PM,

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F 580	Continued From page 6 the Administrator stated if a medication was not available from the pharmacy, they should notify the physician and the DON but deferred any specifics to the DON.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of the Centers for Medicare & Medicaid (CMS) Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure staff accurately coded a Minimum Data Set (MDS) for 4 (Residents #8, #25, #44, and #52) of 22 sampled residents. Findings included: The "Centers for Medicare & Medicaid Resident Assessment Instrument 3.0 User's Manual" version 1.19.1 dated 10/2024 indicated, "1.3 Completion of the RAI" included "Over time, the various uses of the MDS have expanded. While its primary purpose as an assessment instrument is to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments are also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents." The manual indicated, "The RAI process has multiple regulatory requirements"	F 641		

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F 641	Continued From page 7	F 641		

that require "(1) the assessment accurately reflects the resident's status." The manual indicated, "Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician." The manual indicated, "In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations." Per the manual, "It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment."

1. An "Admission Record" indicated the facility admitted Resident #8 on 07/21/2024. According to the Admission Record, Resident #8 had a medical history that included diagnoses of unspecified diastolic (congestive) heart failure, type 2 diabetes mellitus without complications, other obsessive-compulsive disorder, and other abnormalities of gait and mobility.

A quarterly MDS, with an Assessment Reference Date (ARD) of 07/30/2024, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS also indicated that they used another physical restraint in chair or out of

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F 641	Continued From page 8 bed. Resident #8's care plan did not include any information regarding the use of a restraint. An observation on 11/04/2024 at 2:19 PM, revealed Resident #8 was in their wheelchair at activities watching movies with five other residents eating from a snack bag of sour cream and onion chips. No restraints were observed. An observation on 11/06/2024 at 2:31 PM, revealed Resident #8 was in their wheelchair in their room going through some of their personal items and surrounded by personal clutter. No restraints were observed. During an interview on 11/06/2024 at 2:35 PM, Certified Nursing Aide (CNA) #11 stated that she was not aware of any type of restraint used on Resident #8. She further stated that Resident #8 transferred themself and took themself about the facility. During an interview on 11/06/2024 at 2:40 PM, the MDS Coordinator stated that the facility did not have anyone utilizing any type of restraint. After looking at Resident #8's MDS with an ARD of 07/30/2024, she stated that she must have entered restraints by mistake. She stated that it was important that the MDS be accurate because it helped guide their care plan interventions. She stated that she was responsible for ensuring the MDSs were accurate. During an interview on 11/07/2024 at 1:27 PM, the Director of Nurses (DON) stated that she expected that the MDSs be accurate. She stated that it was important for the MDS to be accurate	F 641		

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F 641	Continued From page 9	F 641		

because it needed to be an accurate reflection of the resident, a snapshot of how they were taking care of that person and what their needs were. She stated that the MDS nurse was responsible for ensuring the MDSs were accurate. She stated that her expectation was the MDS Coordinator pull the resident's diagnosis, their care plans, and orders, do a head-to-toe assessment at their bedside, and all information should match.

An interview was held with the Administrator on 11/07/2024 at 1:55 PM. She said that she expected the MDSs to be accurate because it affected patient care. She stated that she expected staff to follow all facility policy and procedures and regulatory guidance.

2. An "Admission Record" indicated the facility admitted Resident #44 on 12/12/2019. According to the Admission Record, the resident had a medical history that included diagnoses of obstructive sleep apnea and dependence on supplemental oxygen.

An annual MDS, with an Assessment Reference Date (ARD) of 09/02/2024, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS did not indicate the resident used a non-invasive mechanical ventilator.

Resident #44's care plan included a focus area revised 10/06/2022 that indicated the resident used oxygen therapy. Interventions directed staff to apply supplemental oxygen as ordered and monitor oxygen saturation and liters per minute

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F 641	Continued From page 10	F 641		

every shift. Further review revealed the resident did not have a care plan for the use of continuous positive air pressure (CPAP) therapy (a type of non-invasive mechanical ventilation).

Resident #44's "Order Recap [Recapitulation] Report" for orders from 08/01/2024 through 11/07/2024 revealed an order dated 10/02/2024 for CPAP therapy continuous at night for sleep apnea. The order indicated the settings on the CPAP machine should be at 4-20 centimeter of water (cmH20) and the water chamber should be emptied and filled with distilled water every night at bedtime.

Resident #44's "Progress Notes" revealed a "Long-Term Care Evaluation" dated 08/30/2024 that indicated the resident received supplemental oxygen via CPAP.

An observation on 11/04/2024 at 10:52 AM revealed a CPAP machine on Resident #44's nightstand with the tubing and mask attached and lying on top of the machine with dried debris in the mask.

During an interview on 11/07/2024 at 9:22 AM, the MDS Coordinator stated the MDS showed a picture of the person, and their care plan was based upon it. She stated the information came from the chart history and interviews with the patient, staff, and therapy. She stated she was responsible for the accuracy of the MDS. She stated if a resident used a CPAP machine, it should be coded on the MDS. She stated Resident #44 did use a CPAP machine, and it should have been coded on the MDS if they used it during that time frame.

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F 641	Continued From page 11 During an interview on 11/07/2024 at 1:11 PM, the Director of Nursing (DON) stated the accuracy of the MDS was important because it was a picture of what was going on with the resident and any type of assessment on the resident needed to be accurate. She stated it was a snapshot of the resident for a period of time. She stated the MDS nurse was responsible for the accuracy of the MDS. During an interview on 11/07/2024 at 1:50 PM, the Administrator stated she expected the MDS to be accurate because it affected all resident care and communication of care but deferred any specifics to the DON. She stated she expected the staff to follow all rules and regulations and their policy and procedures. 3. An "Admission Record" indicated the facility admitted Resident #25 on 03/16/2023. According to the Admission Record, the resident had a medical history that included diagnoses of bipolar disorder, unspecified psychosis, and major depressive disorder. An annual MDS, with an Assessment Reference Date (ARD) of 03/23/2024, revealed the resident had modified independence in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a Staff Assessment of Mental Status (SAMS). The MDS indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability or a related condition. Resident #25's "Preadmission Screening and Resident Review (PASRR) Level I Screening"	F 641		

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F 641	Continued From page 12 dated 03/16/2023 indicated the results of the screening were positive for suspected mental illness. Resident #25's "Preadmission Screening and Resident Review (PASRR) Individualized Determination Letter," dated 03/24/2023, indicated specialized services were recommended that included services and supports that supplement nursing facility care to address mental health needs. The letter indicated recommendations included medication education and training, activities of daily living (ADL) training/reinforcement, supportive services, neuropsychology consultation, psychiatry consultation and/or follow-up care, safety monitors, and behavior monitors. The letters indicated additional functional/medical recommendations included an internal medicine consultation, pain services education, physical therapy, occupational therapy and speech therapy consultations, a dietary consultation, social services consultation, and a continence evaluation. During an interview on 11/07/2024 at 9:22 AM, the MDS Coordinator stated the MDS showed a picture of the person, and their care plan was based upon it. She stated the information came from the chart history and interviews with the patient, staff, and therapy. She stated she was responsible for the accuracy of the MDS. She stated if the resident had a Level II PASRR it was included on the MDS. The MDS Coordinator confirmed the Level II PASRR was not coded on the MDS for Resident #25 but should have been. She stated the Level II PASRR was supposed to be downloaded in the electronic health record or was kept in the back of their hard paper chart.	F 641		

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F 641	Continued From page 13 During an interview on 11/07/2024 at 1:11 PM, the Director of Nursing (DON) stated she expected the MDS to be accurate in relation to the PASRR. She stated if the resident had a level II PASRR it should be coded on the MDS. She stated the accuracy of the MDS was important because it was a picture of what was going on with the resident and any type of assessment on the resident needed to be accurate. The DON stated the MDS was a snapshot of the resident for a period of time. She stated the MDS nurse was responsible for the accuracy of the MDS. During an interview on 11/07/2024 at 1:50 PM, the Administrator stated she expected the MDS to be accurate because it affected all resident care and communication of care but deferred any specifics to the DON. She stated she expected the staff to follow all rules and regulations and their policy and procedures. 4. An "Admission Record" indicated the facility admitted Resident #52 on 03/30/2022. According to the Admission Record, Resident #52 had a medical history that included unspecified anxiety disorder, recurrent major depressive disorder, post-traumatic stress disorder (PTSD), unspecified obsessive-compulsive disorder, and unspecified bipolar disorder. An annual MDS with an Assessment Reference Date (ARD) of 07/08/2024, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS did not reveal Resident #52 had a Level II Preadmission Screening and Resident Review (PASRR). The MDS revealed Resident #52 rejected care one to three days during the assessment period. The	F 641		

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F 641	Continued From page 14 MDS revealed the resident had diagnoses that included anxiety disorder, depression, bipolar disorder, and PTSD. Resident #52's "Preadmission Screening and Resident Review (PASRR) Level I Screening" dated 09/13/2022, revealed Resident #52 had serious mental illness and had been prescribed psychotropic medications for mental illness. The screening revealed that due to the positive Level I PASRR, the state agency determined a Level II mental health evaluation was required. Resident #52's "Preadmission Screening and Resident Review (PASRR) Individualized Determination Report," dated 10/17/2022, revealed there were personal goals recommended for specialized services for Resident #52. During an interview on 11/07/2024 at 8:55 AM, the MDS Coordinator stated that Resident #52's designation as a resident with a Level II PASRR had not been included on the annual MDS assessment and should have been included. The MDS Coordinator stated when coding the MDS she reviewed the resident's electronic medical record and the hard chart for information regarding the PASRR status. The MDS Coordinator stated she was responsible for the completion of the section of the MDS where that PASRR was coded. The Director of Nursing (DON) was interviewed on 11/07/2024 at 1:24 PM. The DON stated she expected the MDS to be accurate and record a resident's Level II PASRR in the correct area. The DON stated the accuracy of the MDS was important because the MDS painted a picture of	F 641		

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F 641	Continued From page 15 the resident. The Administrator was interviewed on 11/07/2024 at 1:50 PM and stated she expected accuracy in documentation on the MDS due to the MDS affected resident care.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires	F 645		

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F 645	Continued From page 16 specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to accurately	F 645		

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F 645	Continued From page 17 complete a Level I Pre-Admission Screening and Resident Review (PASRR) for 2 (Resident #6 and Resident #18) of 6 residents reviewed for PASRR. Findings included: A facility policy titled, "P-NP04 Admission Screening Resident Review (PASRR)," revised on 04/24/2024, indicated, "5. The Facility MDS [Minimum Data Set] Coordinator will be responsible for accessing and ensure updates to the PASRR are completed per MDS guidelines." 1. An "Admission Record" revealed the facility admitted Resident #6 on 07/21/2023. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified bipolar disorder (onset date 07/31/2023), mild recurrent major depressive disorder (onset date 07/31/2023), and generalized anxiety disorder (onset date 07/31/2023). An annual MDS, with an Assessment Reference Date (ARD) of 08/07/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #6 rejected care one to three days during the assessment period. The MDS also revealed the resident had diagnoses of anxiety disorder, depression, and bipolar disorder. Resident #6's "Preadmission Screening and Resident Review (PASRR) Level I Screening" dated 07/29/2023 revealed the screening was "Negative" due to "No Serious Mental Illness."	F 645		

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F 645	Continued From page 18 During an interview on 11/07/2024 at 8:40 AM, the Business Office Manager (BOM) stated residents' PASRRs were completed by the hospital and sent over with the referral or the facility was able to print the PASRR from a website. The BOM stated she was unsure who was responsible for checking the PASRR for accuracy. The BOM stated after admission it was the responsibility of the MDS nurse to check the PASRR to ensure all diagnoses had been included. The MDS Coordinator was interviewed on 11/07/2024 at 8:55 AM. The MDS Coordinator stated the PASRR was completed at the hospital prior to the resident's admission, the facility printed the PASRR, and she was responsible for making sure the PASRR was completed. The MDS Coordinator stated she was also responsible for making sure all needed diagnoses were included and accurate and if the PASRR was not accurate she completed a new one. The MDS Coordinator stated she was unsure who had put the codes for the psychiatric diagnoses into the electronic medical record after Resident #6 was admitted, but stated a new PASRR should have been completed. The MDS Coordinator stated she had not completed a new PASRR for the resident. The MDS Coordinator stated the care Resident #6 received was patient centered and knowing the resident's psychiatric diagnoses could have helped to have more resident centered approaches in caring for the resident. The Director of Nursing (DON) was interviewed on 11/07/2024 at 1:11 PM. The DON stated she expected the PASRR to be accurate and include accurate diagnoses. The DON stated if Resident	F 645		

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F 645	Continued From page 19 #6's PASRR Level I had been accurately completed, a Level II PASRR would have been triggered. The DON stated she did not think having a Level II PASRR would have had influence in the care received by Resident #6. The Administrator was interviewed on 1107/2024 at 1:50 PM and stated she expected documentation to be accurate since the documentation affected resident care. 2. An "Admission Record" revealed the facility admitted Resident #18 on 05/14/2014 and most recently on 05/11/2023. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified bipolar disorder (onset date 10/03/2019), recurrent major depressive disorder (onset date 10/04/2014), and unspecified anxiety disorder (onset date 10/04/2014). A quarterly MDS, with an Assessment Reference Date (ARD) of 08/18/2024, revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS also revealed the resident had diagnoses of anxiety disorder, depression, and bipolar disorder. Resident #18's care plan included a focus area revised on 08/14/2024, that indicated the resident received an antidepressant medication related to depression as evidenced by verbalizations of sadness. The care plan included a focus area revised on 09/18/2024, that indicated Resident #18 received an antipsychotic medication for a diagnosis of bipolar disorder as evidence by the resident continuously shouted out when needs were met. The care plan included a focus area	F 645		

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F 645	Continued From page 20 revised on 08/14/2024 that indicated the resident was on a medication for mood stabilization related to behavioral disturbances that included striking out. Resident #18's "Preadmission Screening and Resident Review (PASRR) Level I Screening Document," dated 11/05/2020, revealed the screening was "Negative;" there was no reason documented as to why the screening was negative. Further review revealed the area to document mental illness, and psychotropic medications had not been completed. During an interview on 11/07/2024 at 8:40 AM, the Business Office Manager (BOM) stated residents' PASRRs were completed by the hospital and sent over with the referral or the facility was able to print the PASRR from a website. The BOM stated she was unsure who was responsible for checking the PASRR for accuracy. The BOM stated after admission it was the responsibility of the MDS nurse to check the PASRR to ensure all diagnoses had been included. The MDS Coordinator was interviewed on 11/07/2024 at 8:55 AM. The MDS Coordinator stated the PASRR was completed at the hospital prior to the resident's admission, the facility printed the PASRR, and she was responsible for making sure the PASRR was completed. The MDS Coordinator stated she was also responsible for making sure all needed diagnoses were included and accurate and if the PASRR was not accurate she completed a new one. The MDS Coordinator reviewed Resident #18's PASRR and stated without the resident's psychiatric diagnoses the Level I PASRR for the	F 645		

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F 645	Continued From page 21 resident was inaccurate and therefore a Level II PASRR had not been completed. The Director of Nursing (DON) was interviewed on 11/07/2024 at 1:11 PM. The DON stated she expected the PASRR to be accurate and to include accurate diagnoses. The DON stated if Resident #18's PASRR had been accurate the resident would have triggered for a Level II PASRR to be completed. The DON stated she did not think having a completed Level II PASSR would have had influence in the care provided for Resident #18. The Administrator was interviewed on 11/07/2024 at 1:50 PM and stated she expected documentation to be accurate since the documentation affected resident care.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		

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F 656	Continued From page 22 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to have a person-centered comprehensive care plan for 2 (Resident #44 and Resident #52) of 22 sampled residents. Specifically, the facility failed to include the use of a non-invasive mechanical ventilator for Resident #44 and Level II Preadmission Screening and Resident Review (PASRR) results for Resident #52 on the comprehensive care plan.	F 656		

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F 656	Continued From page 23 Findings included: A facility policy titled, "Care Planning," revised 03/01/2014, indicated, "It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being." 1. An "Admission Record" indicated the facility admitted Resident #44 on 12/12/2019. According to the Admission Record, the resident had a medical history that included diagnoses of obstructive sleep apnea and dependence on supplemental oxygen. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/02/2024, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS did not indicate the resident used a non-invasive mechanical ventilator. Resident #44's care plan included a focus area revised 10/06/2022 that indicated the resident used oxygen therapy. Interventions directed staff to apply supplemental oxygen as ordered and monitor oxygen saturation and liters per minute every shift. Further review revealed the resident did not have a care plan for the use of continuous positive air pressure (CPAP) therapy (a type of non-invasive mechanical ventilation).	F 656		

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F 656	Continued From page 24 Resident #44's "Order Recap [Recapitulation] Report" for orders from 08/01/2024 through 11/07/2024 revealed an order dated 10/02/2024 for CPAP therapy continuous at night for sleep apnea. The order indicated the settings on the CPAP machine should be at 4-20 centimeter of water (cmH20) and the water chamber should be emptied and filled with distilled water every night at bedtime. Resident #44's October 2024 and November 2024 "Medication Administration Record [MAR]" revealed staff documented that the residents CPAP machine was used every night shift. Resident #44's "Progress Notes" revealed a "Long-Term Care Evaluation" dated 08/30/2024, 09/06/2024, 09/13/2024, 10/04/2024, 10/25/2024, and 11/01/2024 that indicated the resident received supplemental oxygen via CPAP. An observation on 11/04/2024 at 10:52 AM revealed a CPAP machine on Resident #44's nightstand with the tubing and mask attached and lying on top of the machine with dried debris in the mask. During an interview on 11/07/2024 at 9:22 AM, the MDS Coordinator stated she did most of the care planning. She stated the care plan should include anything to let the staff know how to understand and care for a resident. She stated the use of a CPAP machine should be included on the care plan. During an interview on 11/07/2024 at 11:01 AM, Licensed Vocational Nurse (LVN) #4 stated if a resident used a CPAP machine, it should be included on the care plan.	F 656		

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F 656	Continued From page 25 During an interview on 11/07/2024 at 11:05 AM, LVN #5 stated the use of a CPAP machine should be included on the care plan, and the care plan was the responsibility of the MDS Coordinator. During an interview on 11/07/2024 at 1:11 PM, the Director of Nursing (DON) stated she expected the use of a CPAP machine to be included on the care plan. During an interview on 11/07/2024 at 1:50 PM, the Administrator stated the use of CPAP should be included on the care plan. She stated she expected her staff to follow all rules and regulations and the facility's policy and procedures. 2. An "Admission Record" indicated the facility admitted Resident #52 on 03/30/2022. According to the Admission Record, Resident #52 had a medical history that included diagnoses of unspecified anxiety disorder, recurrent major depressive disorder, post-traumatic stress disorder (PTSD), unspecified obsessive-compulsive disorder, and unspecified bipolar disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/08/2024, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS did not reveal Resident #52 had a Level II PASRR. The MDS revealed Resident #52 rejected care one to three days during the assessment period. The MDS revealed Resident #52 had diagnoses that included anxiety disorder, depression, bipolar disorder, and PTSD.	F 656		

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F 656	Continued From page 26 Resident #52's "Preadmission Screening and Resident Review (PASRR) Individualized Determination Report," dated 10/17/2022, revealed that personal goals were considered in making recommendations for specialized services and included increased contact with the resident's family, address the resident's weight concerns, improve the resident's dentition, improve hearing and mobility, request in home care assistance, podiatry services, improve memory, reduce depression, improve well-being, and provide a neurological assessment. Resident #52's care plan revealed no evidence of a focus area for Resident #52's Level II PASRR and the personal goals and individualized recommendations given for specialized services included on the resident's 10/17/2022 "Preadmission Screening and Resident Review (PASRR) Individualized Determination Report." The MDS Coordinator was interviewed on 11/07/2024 at 8:55 AM. The MDS Coordinator stated because Resident #52 had a Level II PASRR with additional services, the Level II PASRR designation and the additional services should have been care planned. The MDS Coordinator stated she was responsible for most of the care plans, and it was her fault Resident #52's Level II PASRR had not been included in the resident's care plan. The Director of Nursing (DON) was interviewed on 11/07/2024 at 1:24 PM. The DON stated if Resident #52 had a Level II PASRR with specific recommendations from the reviewer she expected both the Level II designation, and the recommendations would be care planned.	F 656		

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F 695	Continued From page 27	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(l) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure non-invasive mechanical ventilation equipment was cleaned and stored properly for 1 (Resident #44) of 3 residents reviewed for respiratory care. Findings included: A facility policy titled, "BiPAP [bilevel positive airway pressure] and CPAP [continuous positive airway pressure]," dated 09/10/2020, specified, "Continuous Positive Airway Pressure (CPAP) is delivered in a single constant pressure during inhalation and exhalation. BIPAP is the Bilevel Positive Airway Pressure or Non-Invasive Positive Pressure Ventilation (NPPV) that delivers two pressures, lesser pressure delivered on exhalation and a second greater pressure on inhalation." The policy also indicated, "VIII. Cleaning" included "A. Keep the outside of the machine free from dust and debris. Clean using a cloth and disinfectant weekly and as needed. B. Replace the hose weekly and as needed. C. Disassemble the CPAP/BIPAP mask by removing	F 695		

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F 695	Continued From page 28	F 695		

the head hear (straps) and cushion from face D. Replace head gear (straps) weekly or as needed for soiling. E. As needed, wash mask with warm soapy water (no fragrance or colored soap), rinse and dry F. Daily and/or after every use, wash humidification chamber with warm soapy water (no fragrance or colored soap) G. All equipment should be kept in a plastic bag or container labeled with the Resident's name when not in use H. Filters should be changed every two weeks or as specified by the manufacturer."

An "Admission Record" indicated the facility admitted Resident #44 on 12/12/2019. According to the Admission Record, the resident had a medical history that included diagnoses of obstructive sleep apnea and dependence on supplemental oxygen.

An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/02/2024, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS did not indicate the resident used a non-invasive mechanical ventilator.

Resident #44's care plan included a focus area revised 10/06/2022 that indicated the resident used oxygen therapy. Interventions directed staff to apply supplemental oxygen as ordered and monitor oxygen saturation and liters per minute every shift. Further review revealed the resident did not have a care plan to address the use of CPAP therapy.

Resident #44's "Order Recap [Recapitulation] Report" for orders from 08/01/2024 through

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F 695	Continued From page 29 11/07/2024 revealed an order dated 10/02/2024 for CPAP therapy continuous at night for sleep apnea. The order indicated the settings on the CPAP machine should be at 4-20 centimeter of water (cmH20) and the water chamber should be emptied and filled with distilled water every night at bedtime. Resident #44's October 2024 and November 2024 "Medication Administration Record [MAR]" revealed staff documented that the residents CPAP machine was used every night shift. An observation on 11/04/2024 at 10:52 AM revealed a CPAP machine on Resident #44's nightstand with the tubing and mask attached and lying on top of the machine with dried debris in the mask. Observations on 11/05/2024 at 11:54 AM, 11/06/2024 at 8:32 AM, and 11/07/2024 at 9:11 AM, revealed Resident #44's CPAP machine on the nightstand had no water in the humidifier chamber, and the mask and tubing were attached lying on top of the machine with dried debris in the mask. During an interview on 11/07/2024 at 11:01 AM, Licensed Vocational Nurse (LVN) #4 stated respiratory equipment should be stored in a plastic bag that kept it free from bacteria for infection control. She stated the resident should have a holder to keep the equipment in and the equipment was changed once a week by whatever shift it was scheduled on the MAR. During an interview on 11/07/2024 at 11:05 AM, LVN #5 stated that when respiratory equipment was not in use it should be stored in a bag for	F 695		

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F 695	Continued From page 30 infection control purposes. During an interview on 11/07/2024 at 11:07 AM, LVN #6 stated the CPAP mask should be stored inside a bag when not in use and the mask should be wiped off after each use. She confirmed that Resident #44's CPAP mask was not clean or being stored appropriately. She stated they should be using distilled water in the humidifier chamber, and it was kept in the medication room. During an interview on 11/07/2024 at 1:11 PM, the Director of Nursing (DON) stated respiratory equipment should be cleaned after each use, and the residents had microbial bags to store them in. She stated the CPAP mask should be cleaned daily after use, the whole headgear should be cleaned weekly, and the filter changed every two weeks. During an interview on 11/07/2024 at 1:50 PM, the Administrator stated the staff should be following the facility policy and procedures and thought the respiratory equipment should be stored in a bag but deferred all nursing and care related subjects to the DON.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		

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F 755	Continued From page 31 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure medications were received from the pharmacy in a timely manner for 1 (Resident #58) of 6 residents reviewed for unnecessary medications. Findings included: A facility policy titled, "Medication Ordering and Receiving From Pharmacy," dated 02/2008, indicated, "Medications and related products are received from the dispensing pharmacy on a timely basis."	F 755		

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F 755	Continued From page 32 An "Admission Record" indicated the facility admitted Resident #58 on 08/17/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of bipolar disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/27/2024, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #58's care plan included a focus area initiated 05/31/2023 that indicated the resident used psychotropic medications related to bipolar disorder. Interventions directed staff to administer psychotropic medications as ordered by the physician and monitor for side effects and effectiveness every shift. Resident #58's September 2024 "Medication Administration Record [MAR]" revealed a transcription of an order for Depakote tablet delayed release 250 milligrams (mg) with instructions to give 250 mg by mouth at bedtime for bipolar disorder. The MAR revealed that on 09/29/2024 and 09/30/2024 Depakote was coded "9" (other/see progress notes). Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 09/29/2024 that indicated the resident's Depakote was not available in the facility. An Orders-Administration Note dated 09/30/2024 indicated the resident's Depakote was reordered and was not available in the facility. Resident #58's October 2024 MAR revealed a	F 755		

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transcription of an order for Depakote tablet delayed release 250 mg with instructions to give 250 mg by mouth at bedtime for bipolar disorder. The MAR revealed that on 10/07/2024, 10/08/2024, 10/10/2024, and 10/12/2024 through 10/17/2024 Depakote was coded "9" (other/see progress notes).

Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/07/2024 and 10/08/2024 that indicated the resident's Depakote was not available in the facility.

Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/10/2024 that indicated the resident's Depakote was reordered and had not been received.

Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/12/2024 that indicated the resident's Depakote was reordered.

Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/13/2024 that indicated they were waiting on delivery of the resident's Depakote from the pharmacy.

Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/14/2024 that indicated the resident's Depakote had not been received.

Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/15/2024 that indicated the resident's Depakote was unavailable.

Resident #58's "Progress Notes" revealed an

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F 755	Continued From page 34 "Orders-Administration Note" dated 10/16/2024 that indicated they were waiting for delivery of the resident's Depakote. Resident #58's "Progress Notes" revealed an "Orders-Administration Note" dated 10/17/2024 that indicated the resident's Depakote had not been received. A "Packing Slip," dated 08/29/2024, indicated Resident #58 had 30 tablets of divalproex (Depakote) 250 mg delivered from the pharmacy and signed for by facility staff. A "Packing Slip," dated 10/18/2024, indicated Resident #58 had 30 tablets of divalproex (Depakote) 250 mg delivered from the pharmacy and signed for by facility staff. During an interview on 11/06/2024 at 2:41 PM, Licensed Vocational Nurse (LVN) #1 stated if a medication were not available while passing medications, she would look for the medication in the cart and throughout the facility. She stated she would check the kit that they had for emergency medications to see if it was available. She stated if the medications were not in the facility, she would notify the resident, the resident representative, physician, and pharmacy. She stated she would call the pharmacy to find out when it was coming and let the physician know and get orders from the physician to hold the medication until it arrived. She stated if she came in the next day and the medication was still not there, she would repeat the process. She stated it would be up to the physician to determine if a new order was needed. She stated she only worked every two weeks and did not specifically remember the Depakote not being available for	F 755		

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F 755	Continued From page 35 Resident #58 or what she did about it. During an interview on 11/06/2024 at 2:52 PM, LVN #2 stated if a medication were not available, she would look at the overflow medications and then she would check to see if it was reordered. She stated, if it were reordered, she would call the pharmacy to find out where it was and when it was going to arrive. She stated she would fax the physician and let him know. She stated the faxes should be kept in the resident's medical record. LVN #2 stated a resident should not go longer than 24 hours without receiving their medication. She stated she was having a lot of trouble getting Resident #58's Depakote from the pharmacy and had to keep calling them. She stated she did not notify any of the nurse managers or Director of Nursing (DON). She stated she did not recall if she notified the physician but would have sent him a fax, and those were kept in medical records. During an interview on 11/06/2024 at 3:03 PM, LVN #3 stated if a medication were not available, she would look in the cart and the overflow medications and check other residents' medications to make sure it did not get mixed up with them. She stated if she were not able to find the medication then she would call the pharmacy, fax the physician that the medication was not available, notify the family or responsible party, and monitor for side effects. She stated she could not remember if she notified the physician but stated if she did, the fax should be in the resident's medical record. During an interview on 11/07/2024 at 11:01 AM, LVN #4 stated if a medication was not available, she would look in the cart and the medication	F 755		

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room, check the emergency medication kit, and call the pharmacy, and if a dose was missed, then she would call the physician and the responsible party. She stated a resident should not go longer than 24 hours without their medication and the DON should be notified right away so she could follow up on it.

During an interview on 11/07/2024 at 11:05 AM, LVN #5 stated if a medication were not available during medication pass, she would look in the overflow medications, medication room, and other carts. She would check to see if it was available in the emergency kit, and if it was still not available, she would call the pharmacy to see if it was ordered and when it could be delivered. She stated the physician should be notified if the resident missed a dose and to get an order to administer the medication when it arrived from the pharmacy. She stated a resident should not go longer than a day without their medication. She stated if she had difficulty getting the medication, she would notify the DON and the physician, because they may want to change the medication.

During an interview on 11/07/2024 at 11:07 AM, LVN #6 stated if a medication was not available, she would check inside the medication room, see if it was available in the emergency kit, and if it was not there, then she would call the pharmacy and have them deliver it. She stated if she came back the next day, and the medication was still not available, she would call the pharmacy back and call the physician, responsible party, and the DON to let them know. She stated a resident should not miss any doses of medications but definitely not go longer than a shift without the medication being obtained. She stated she would

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document the missed dose in a progress note and place the resident on alert charting to monitor for adverse effects. LVN #6 stated the DON should have been notified when the nurse was not able to get Resident #58's Depakote from the pharmacy, and the resident should not have gone that many days without the medication.

During an interview on 11/07/2024 at 11:31 AM, the Medical Records Supervisor stated they did not have any faxes to the physician regarding Resident #58's Depakote not being available.

During an interview on 11/07/2024 at 11:54 AM, the Medical Director stated he would get over 50 faxes a day and did not recall receiving information that Resident #58 did not receive their Depakote. He stated he did not know why the medication would not be available from the pharmacy. He stated the resident took the Depakote as a mood stabilizer and since they did not get it, they could possibly have an unstable mood. The Medical Director stated if the resident was stable after missing the doses, it would have actually been a good gradual dose reduction.

During an interview on 11/07/2024 at 12:45 PM, a Pharmacy Representative stated they got a fax on 10/18/2024 for a request for the Depakote for Resident #58, and it was delivered that day. She stated otherwise they did not have a way of telling when the facility ordered a medication, only when it was delivered.

During an interview on 11/07/2024 at 1:11 PM, the DON stated the process the nurses should follow when a medication was not available was to call the pharmacy, and if they were not able to get the medication during their shift, they should let the

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056258	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY HEALTHCARE & WELLNESS CENTRE, LP	2490 COURT STREET REDDING, CA 96001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 38 physician know. She stated they may be able to get the medication from the emergency medication kit or get the physicians to change the order to something else that was available in the emergency kit if needed. She stated a missed dose was a missed dose and should be followed up on immediately. She stated she was not aware of Resident #58's Depakote not being available and had not been notified by any of the staff. During an interview on 11/07/2024 at 1:50 PM, the Administrator stated if a medication was not available, the nurse should notify the physician and the DON but deferred specifics to the DON.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		

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F 756	Continued From page 39 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to notify the physician of pharmacy consultant recommendations for 1 (Resident #56) of 6 residents reviewed for unnecessary medications. Findings included: A facility policy titled, "Consultant Pharmacist Reports" "IIIAI: Medication Regimen Review," revised 01/2018, indicated, "All findings and recommendations are reported to the director of nursing and the attending physician the medical director and the administrator." The policy also indicated, "G. Recommendations are acted upon and documented by the facility staff and/or the prescriber." An "Admission Record" indicated the facility admitted Resident #56 on 07/11/2022. According to the Admission Record, the resident had a	F 756		

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F 756	Continued From page 40 medical history that included a diagnosis of major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/21/2024, revealed Resident #56 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident received an antidepressant during the last seven days of the assessment period. Resident #56's care plan included a focus area revised 10/27/2024 that indicated the resident used an antidepressant medication for depression as evidenced by withdrawal from activities of interest. Interventions directed staff to administer antidepressant medications ordered by the physician and monitor and document side effects and effectiveness every shift. Resident #56's physician orders revealed an order dated 08/24/2023 for escitalopram oxalate 5 milligrams (mg) by mouth one time a day for depression. Resident #56's August 2024 "Medication Administration Record [MAR]" revealed staff documented that the resident received escitalopram oxalate 5 mg by mouth every day at 8:00 AM. Resident #56's "Consultant Pharmacist's Report" dated 08/26/2024 indicated the resident had been receiving escitalopram 5 mg by mouth every day since 07/11/2022. The report recommended evaluating this therapy to determine if symptoms, conditions, or risks could be managed by a lower dose or if the medication could be discontinued.	F 756		

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F 756	Continued From page 41 The report indicated to document if a gradual dose reduction (GDR) or discontinuing the medication was clinically contraindicated. Further review revealed the report had not been signed or dated by the prescriber. During an interview on 11/07/2024 at 1:11 PM, the Director of Nursing (DON) stated it was her responsibility to follow up on the pharmacy recommendations. She stated they were not able to find the follow up for the recommendations for Resident #56's GDR for the month of August 2024. She stated the pharmacy consultant reviewed records monthly, and they were to be faxed to the DON the following day and then she would follow up on them immediately. During an interview on 11/07/2024 at 1:50 PM, the Administrator deferred all nursing and related subjects to the DON but stated she expected the staff to follow all rules and regulations and their policy and procedure.	F 756		

Starting 12/02/24, The RQMC or RAI specialist staff will conduct an audit of P0110, O0110 G and A1500 the for scheduled MDS assessments. Any findings identified will be corrected according to the RAI manual before closing the MDS assessments, weekly x 4, then monthly x 2 months or substantial compliance maintained.

Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not reoccur:

The MDS Coordinator will report the findings of the MDS Assessment Accuracy Audits to the Quality Assurance and Performance Improvement Committee Meeting every month for three months. After that, the report shall be presented quarterly until the facility attains substantial compliance.

River Valley Healthcare & Wellness Centre

F 645 PASARR Screening
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River Valley Healthcare & Wellness Centre

F 641
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F 641: Accuracy of Assessments

Corrective action for residents found to have been affected by this deficiency:

On 11/06/2024, the MDS assessments completed on 7/30/24 for Resident #18, was modified and transmitted by the MDS coordinator to reflect the correct coding of P0110-restraints
On 11/06/24, the MDS assessment completed on 9/02/2024 for the resident #44, was modified and transmitted by the MDS coordinator to reflect the CPAP use correctly coded of O 00110 G3
On 11/09/24, the MDS assessment completed on 03/23/24 for resident # 25,and MDS assessment completed on 7/08/24 for resident # 52, was modified and transmitted by the MDS coordinator to reflex level 2 PASRR, of A1500

On 11/27/2024, the Regional Quality Management Consultant(RQMC) provided in-service training to the MDS Coordinator The training covered coding accuracy and MDS coding of Restraints, CPAP, and PASARR's as per the RAI manual.

Corrective action for residents that may be affected by this deficiency:

On 11/06/24, the DON conducted an audit of the MDS assessments in the last 90 days for Restraints, P0110, and O 00110 G3 where coded per the as per the RAI manual, no other inaccurate coding was noted.
On 11/09/24, the RQMC conducted and audit of Level 2 PASRR, and 2 additional modification where made.
MDS coordinator completed a new PASARR on residents with DX of Schizophrenia, by 11/15/25
Measures put into place or systematic changes that facility will make to ensure that the deficient practice does not occur again:

Starting 11/10/2024, The MDS Coordinator will review the scheduled MDS assessments and ensure that P0110, O0110 G and A1500 is coded appropriately on MDS before transmitting the assessment.

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

MDS coordinator complete a on 11/9/24 for PASRR for resident # 6 with DX of Bipolar to ensure they accurately reflect resident current status.

MDS coordinator complete a on 11/9/24 for PASRR for resident # 18 with DX of Bipolar to ensure they accurately reflect resident current status.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All residents have potential to be affected by the deficient practice

1.RQMC provided Inservice Training to admissions coordinator, DON, MDS, Administrator, on PASRR process and level 2 review
3. Facility will complete a PASRR resident review for all residents in facility and will update as appropriate to reflect residents' status, during chart review/admission process, with new DX and annually

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

1.Upon admission /readmission Admissions Coordinator/ Designee will complete PASRR within 24 hours of admission and scan into the electronic health record

2.Medical Records Director /Designee will complete monitoring tool for accuracy and completion of PASSRR upon admissions and readmission and report any negative findings 1 x week to Administrator in the daily in stand up

How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.

1.Medical Records /Designee will report any negative findings to the QAA committee on a quarterly basis for the next two quarters for review and recommendation. This process will be monitored by the Administrator and DON

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POC FOR F656 SS= D

Develop/Implement Comprehensive Care plan CFR(s): 483.21(b)(1)(3)

1. Resident #44 and #52 have been reassessed by the IDT on 11/7/24. Patient #44 care plan was updated to include Cpap usage as well as maintenance of machine. Patient #52 care plan was updated to include a level 2 passar. Both patients are at baseline with no change in condition.

2. Audit was performed using order listing report with two additional patients identified as triggered for a level 2 passar with care plan updated 11/27/24. One additional patient was identified with cpap care plan being updated to include maintenance and care on 11/7/24. The Clinical Meeting held Monday through Friday under the guidance of the Director of Nursing will review all patients with new orders for CPAP, new admission audit to include passar accuracy.

3. Education was provided on 11/7/24 to IDT team on assuring compliance of initiation of passar level care plan as well as cpap care plans. Education was provided on the importance of implementing a cpap care plan on the day of order as well as passar changes. Nursing educated to implement care plans was provided by the Director of Nursing and Director of Staff Development and Assistant Director of Nurses. Additional training will be provided as needed.

4. During Clinical Meeting held Monday through Friday, will review order listing report as well as new admission audits for any needed care plan revisions. Any trends or concerns identified will be addressed immediately and additional education provided and counseling if appropriate. Monitoring of the results of findings will be presented by the Director of Nursing at the monthly Quality Assurance Meeting for three months. If identified, additional recommendations will be made under the guidance of the Executive Director and committee and implemented until substantial compliance is met and sustained.

5. Completion Date: 12/12/24

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POC for F695 Respiratory /Tracheostomy Care and Suctioning CFR(s):483.25(i)

Resident #44 Cpap mask was cleaned and placed in an antimicrobial bag with date for 11/7/24. Orders were placed in computer for weekly cleaning of mask, daily cleaning of humidifier chamber to use distilled water and to be placed in antimicrobial bag when not in use.

No other residents have been identified through order listing report as well as building sweep for any additional cpap machines not identified. The Clinical meeting held Monday-Friday under the guidance of the Director of Nursing Services will identify any new orders for Cpap or new admissions with cpap usage.

Education provided to the Licensed nurses and the IDT team on assuring compliance with proper care of Cpap machines by 12/13/24. Training included review by IDT in clinical meeting of all new admissions for need for Cpap as well as reviewing of order listing report to ensure all proper orders are obtained for cpap maintenance on 11/7/24. All maintenance orders will be implemented for Sunday Noc shift with IP checking each Monday morning for compliance. This training was provided by DON, DSD and ADON. Additional training will be provided as indicated.

Medical records to audit completion of weekly maintenance orders for cpap weekly and present to IDT team Monday-Friday during clinical standup weekly for 4 weeks, then monthly x2 until satisfactory compliance is met and sustained. Any concerns or trends identified will be addressed immediately and additional education provided and counseling if appropriate. Monitoring of the results of findings will be presented by the Director of Nursing at the monthly Quality Assurance Meeting x3 months. If identified, additional recommendations will be made under the guidance of the Executive Director and committee and implemented until substantial compliance is met and sustained.

Completion date

12/12/24

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POC F755 Pharmacy Svs/procedures/Pharmacist/Records CFR(s):483.45(a)(b)(1)-(3)

Resident #58 has been receiving medication since delivered on 11/17/24, MD notification, and labs done on 11/4/24.

Audit and review of all patients, using the order listing report on 11/7/24, all medications available. No additional patients affected.

Education provided to Licensed Nurses and the IDT clinical team on assuring compliance on ensuring medications availability by ~~12/10/24~~ 12/5/24. The policy for medication administration was provided to licensed nurses with emphasis on procedure for medication unavailable to include, call to pharmacy to request medication if unavailable in Ekit, call to MD for possible alternative medication, SBAR with notification to RP and DON. IDT clinical review will occur Monday-Friday to review all medications unavailable and ensure compliance. The training was provided by the Director of Nursing, Staff Development Director and Assistant to Director of Nursing. Additional training will be provided as indicated.

Clinical review and care audits will be done by medical records daily to ensure all medications available. Clinical IDT will review all notes related to medication not available to ensure medication delivered. Any concerns or trends will be addressed immediately and additional education provided and counseling if appropriate. Monitoring of the results of findings will be presented by the Director of nursing at the monthly Quality Assurance Meeting x3 months. If identified, additional recommendations will be made under the guidance of the Executive Director and committee and implemented until substantial compliance is met and sustained.

Completion date
~~12/12/24~~ 12/5/24

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F756 Drug Regimen Review, Report irregular, Act on CFR(s):483.45(c)(1)(2)(4)(5)

Resident #56 pharmacy recommendations provided to MD with all recommendations and orders completed on

Pharmacist reviewed all residents on 10/28/24 and again on 11/21/24 for any required recommendations. All recommendations provided to MD of patient for review with orders completed.

Educations provided to licensed nurses as well as IDT related to pharmacy recommendations and process by 12/12/24. Recommendations emailed to Director of Nursing and Assistant Director of Nursing. Recommendations will be printed and provided to physicians and to be returned to Director of Nursing. Assistant Director will process all orders with copy to be kept in Director of Nursing office in binder with original to be in patient chart. The training was provided by the Director of Nursing and Assistant Director of Nursing. Additional training will be provided as indicated.

Assistant Director of Nursing will assure compliance through audit of all recommendations for the month being returned and marked as complete. . Any trends or concerns identified will be addressed immediately and additional education provided and counseling if appropriate. Monitoring of the results of findings will be presented by the Director of Nursing at the monthly Quality Assurance Meeting for three months. If identified, additional recommendations will be made under the guidance of the Executive Director and committee and implemented until substantial compliance is met and sustained.

Completion Date: 12/12/24

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F580 Notify of Changes (Injury/Decline/Room,etc) CFR(s):483.10(g)(14)(i)=(iv)(15)

Resident #58 Depakote received 10/18/24 and administered daily with no further missed doses. Patient is at baseline without any change of condition.

No other residents have been identified through order listing report, MAR audit as well as progress notes. The Clinical Meeting held Monday through Friday under the guidance of the Director of Nursing Services will identify any missed medication doses.

Education was provided to licensed nurses as well as IDT team on assuring compliance with medication administration, process related to medications when unavailable by 12/10/24. In addition, training included medication administration policy provided to all IDT team members as well as licensed staff, pharmacy after hour's numbers provided, process to include notification to pharmacy request for medication, if medication not available in Ekit MD to be called with notification and request for alternate as appropriate, SBAR in PCC, call to RP and Director of Nurses. The IDT clinical meeting held Monday through Friday will review all SBAR related to missed doses of medications. The training was provided by Director of Nursing, Director of Staff Development and Assistant Director of Nurses. Additional training will be provided as indicated.

Daily review of all SBAR will be done Monday through Friday to ensure all medications have been administered and process followed. Any trends or concerns identified will be addressed immediately and additional education provided and counseling if appropriate. Monitoring of the results of findings will be presented by the Director of Nursing at the monthly Quality Assurance Meeting for three months. If identified, additional recommendations will be made under the guidance of the Executive Director and committee and implemented until substantial compliance is met and sustained.

5. Completion Date: 12/12/24