STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055001	A. BUILDING _____ B. WING _____	C 06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDLANDS HEALTHCARE CENTER	1620 WEST FERN AVENUE REDLANDS, CA 92373

(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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey to investigate a complaint. Complaint number: CA00579899 Representing the California Department of Public Health: 37363 The investigation was limited to a specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for the complaint: CA00579899	F 000	Redlands healthcare center submits this Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that medications were not left with one of three sampled resident (Resident 1) who was not approved for self-administration of medications. This failure resulted in Resident 1 not taking a dose of two Norco tablets (a narcotic pain medication) at 5:30 PM, and adding them to her 9 PM dose of two Norco tablets. This placed her at risk of overmedication. Findings:	F 554	Resident 1 was discharged on 4/2/18. 1:1 in-service provided to LVN 1 on 3/23/18 on policy and procedure on self-administration of med and administration of medications by DON, skill competency for medication Continue to page 2	

accepted QPR with POC 6/18/18

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

DON 6/13/18

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 554	Continued From page 1 A review of the face sheet for Resident 1 on March 29, 2018, at 3:40 PM, indicated that she was readmitted to facility on March 2, 2018 with diagnoses which included low back pain. A review of the "Physician orders" for Resident 1 on April 2, 2018 at 4:35 PM, indicated that Resident 1 had an order for Norco (a narcotic pain medication) 5-325 mg (mg - a unit of measurement) two tablets by mouth every four hours as needed for generalized body pain. During an interview with the Licensed Vocational Nurse (LVN 1) on April 19, 2018 at 2:13 PM, she stated, "At around 5-5:30 PM on March 22, 2018 during my med pass I gave [name of Resident 1] in her room, her Norco two tablets (routine medication for pain), along with her methadone (pain medication), xanax (antianxiety medication) and other medications which I can't remember. I gave the meds. in four separate cups. I went outside due to urgency as a another resident was screaming. I came right back in and she (Resident 1) said she took all her pills." LVN 1 confirmed she did not stay with Resident 1 to observe that she swallowed all of her medications. During a concurrent interview with LVN 1 when asked why she did not bring whatever medications she had not administered yet to Resident 1 with her when she needed to leave so quickly, she stated "It happened so fast due to the emergency I was not able to watch Resident 1 take all her meds. I did not know she kept the two Norcos I gave her at 5:30 PM. It was my fault." During an interview with the Director of Nursing	F 554	Continued from page 1 administration for LVN 1 completed by DON on 3/23/18. Other residents have the potential to be affected by this practice – IDT reassessed other residents that may require self-administration orders. Other resident identified admitted with the past 2 months effective on 6/13/18 self-administration assessment done. No other residents identified to be needing self-administration of meds. In-service with Licensed Nurses on policy and procedure of medication administration which include ensuring meds were taken by resident as ordered and self-administration of medication provided by DON on 6/7/18, 6/8/18, and 6/11/18. Assessment of residents for self-administration will be completed by licensed nurses upon admission, by MDS coordinators on quarterly, annual and significant change in condition. Continue to page 3	

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F 554	Continued From page 2 (DON) on April 19, 2018 at 2:40 PM, she confirmed that the licensed nurses must watch their residents actually taking their medications. The facility policy and procedure titled " Administering Medications " undated, indicated under " Policy Interpretation and Implementation ... 24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have decision-making capacity to do so safely."	F 554	Continue from page 2 Medical Records Director will audit new admits, quarterly assessments, significant changes in condition if self-med administration has been completed – findings will be reported to DON for follow up. Medication Pass competency skills will be completed by DON / designee with 1 Licensed Nurses per week until all Licensed nurses completed then medication pass skills competency will be done by DON/designee with newly hired licensed nurses and annually and as needed for compliance with the medication administration. The DON will report audit findings of medical records and skills competency for medication administration to monthly QAA meeting for further recommendations for the next 3 months then reevaluate need for reporting.	