| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaints #CA00834806 and #CA00835933.<br><br>Representing the Department of Public Health: Health Facilities Evaluator Nurse, 32096<br><br>The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. | F 000 | ~~DISCLAIMER CLAUSE~~<br>PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. | |
| F 698 SS=D | Dialysis<br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2), received hemodialysis treatment (a procedure to remove waste products and excess fluid from the blood via a machine when the kidneys fail), when Resident 2 was incorrectly transported to a non-dialysis healthcare clinic and missed her appointment.<br><br>This failure resulted in Resident 2 to miss her scheduled dialysis treatment.<br><br>Findings: | F 698 | **F689 – Dialysis CFR(s) 483.25(l)**<br><br>***Correction for resident(s) affected:***<br>Resident 2 successfully received a make-up dialysis appointment on 4/13/23.<br><br>***How to identify residents with potential to be affected by similar practice:***<br>Residents with orders to receive dialysis treatments have the potential to be affected by similar practice. The DON reviewed other residents with dialysis orders on 4/18/23. No other residents were identified.<br><br>***Measures taken and put in place to maintain systematic changes:***<br>The facility's policy for ""Transporting residents to appointments (Non-Emergency)" was reviewed/revised by the QAA Committee on 4/20/23.<br><br>By 5/12/23, the DSD/DON/Administrator/Designee will in-service staff to the facility Policy titled | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristine Perry | TITLE: Administrator | (X6) DATE: 5/15/23

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 698 | Continued From page 1<br>Resident 2 was a long-term resident in the facility with diagnoses that included end stage renal disease (a permanent kidney failure that requires regular dialysis treatment) and had intellectual disabilities.<br><br>In an observation on 4/18/23 at 11:46 a.m., Resident 2 was lying in bed, on her side, facing the wall with her eyes open. The resident did not respond to a greeting.<br><br>Review of Resident 2's MDS (Minimum Data Set, an assessment too), dated 2/28/23, indicated the resident was "severely impaired" in cognitive skills for daily decision making.<br><br>Review of Resident 2's medical record included a physician order, dated 4/6/23, for dialysis treatment three times a week on Mondays, Wednesdays, and Fridays at a nearby dialysis clinic. The physician order specified the time that the resident needed to be at the dialysis clinic for the scheduled treatment, "Chair time is 13:45 [1:45 p.m.]. Needs to be at dialysis Clinic by 13:30 [1:30 p.m.]".<br><br>Review of Resident 2's medical record, SBAR [Situation, Background, Assessment, Recommendation] Communication Form, dated 4/12/23, indicated, "Resident missed dialysis today."<br><br>In an interview on 4/18/23 at 12:42 p.m., the Social Service Assistant (SSA) stated Resident 2 missed her 4/12/23 dialysis treatment because she was inadvertently taken to a podiatry clinic instead of her dialysis treatment clinic. The SSA explained a transportation service was scheduled to pick up another resident who had a podiatry | F 698 | ~~"Transporting residents to appointments~~ (Non-Emergency)".<br><br>***Monitoring to ensure solution is sustained:***<br>The Unit Clerk or Designee will verify that residents are transported to their scheduled appointments as ordered. Findings will be followed up on immediately and will be reported to the Administrator/DON and Quality Assurance Performance Improvement (QAPI) committee until substantial compliance is met and maintained or as determined by the QAPI committee.<br><br>***Person(s) responsible for correction:***<br>The Administrator is responsible for this correction, alleging compliance on 05/12/2023.<br><br>**F745 – Provision of Medically Related Social Service CFR(s) 483.40(d)**<br><br>***Correction for resident(s) affected:***<br>Resident 1 successfully attended her podiatry appointment on 4/12/23.<br><br>***How to identify residents with potential to be affected by similar practice:***<br>Residents with orders for outside appointments have the potential to be affected by similar practice. On 4/18/23, the DON reviewed other residents with appointments within the last week. No other residents were identified.<br><br>***Measures taken and put in place to maintain systematic changes:*** | |

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| F 698 | Continued From page 2<br>appointment on 4/12/23, mistakenly picked up Resident 2 and took the resident to the podiatry clinic. The SSA stated on 4/12/23 Resident 2 was in the lobby waiting for her dialysis transportation van when she was picked up and taken to the wrong clinic. The SSA stated by the time Resident 2 was brought back to the facility, she had already missed her appointed seat at the dialysis clinic. The SSA stated the facility staff should have supervised the resident's pick up at the lobby and identified the resident's name and the scheduled appointment for the pick up driver especially as Resident 2 had a developmental delay and she could have said yes to anything. | F 698 | The facility's policy for ""Transporting residents to appointments (Non-Emergency)" was reviewed/revised by the QAA Committee on 4/20/23.<br><br>By 5/12/23, the DSD/DON/Administrator/Designee will in-service staff to the facility Policy titled "Transporting residents to appointments (Non-Emergency)".<br><br>***Monitoring to ensure solution is sustained:***<br>The Unit Clerk or Designee will verify that residents are transported to their scheduled appointments as ordered. Findings will be followed up on immediately and will be reported to the Administrator/DON and Quality Assurance Performance Improvement (QAPI) committee until substantial compliance is met and maintained or as determined by the QAPI committee.<br><br>***Person(s) responsible for correction:***<br>The Administrator is responsible for this correction, alleging compliance on 05/12/2023. | |
| F 745 SS=D | Provision of Medically Related Social Service CFR(s): 483.40(d)<br><br>§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure medically related social services were provided timely for one of three sampled residents (Resident 1) when transportation services did not show up to assist Resident 1 to a physician appointment and the transportation service picked up the wrong resident for Resident 1's podiatrist appointment outside the facility.<br><br>These failures resulted in Resident 1 being late for the doctor's appointments and the family member hurriedly arranging the transportation for the resident to meet the appointment. | F 745 | | |

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| F 745 | Continued From page 3<br>Findings:<br><br>Resident 1 was admitted to the facility early this year with diagnoses that included one sided paralysis of her body after bleeding in the brain and had memory problems.<br><br>In a telephone interview on 4/11/23 at 4:09 p.m., Resident 1's Representative (RR) stated the facility did not provide transportation for Resident 1's doctor's appointment scheduled on 3/20/23. RR stated she reminded the facility "multiple times" of the resident's appointment and was told by [Staff Name] that the transportation was arranged. RR stated, on 3/20/23, she arrived at the doctor's office for the 11 a.m. appointment and waited for Resident 1; however, the resident did not come to the clinic past 11 a.m. RR stated she called the facility about Resident 1 and was told Resident 1 was still at the facility and the resident's name was not on the transportation roaster. RR stated while she was on the phone with the facility, she was told they would arrange the transportation as soon as possible for the resident's appointment. RR stated she was able to postpone the resident's appointment from 11 a.m. to 2:30 p.m. the same day and waited for the resident. RR voiced the facility was not able to provide the transportation for the 2:30 p.m., either, therefore, the resident's family member had to rush to the facility to pick up the resident and brought her to the clinic for the 2:30 p.m. appointment. RR complained the facility promised to provide the transportation and did not provide the necessary service for Resident 1. RR stated had the facility informed her that the transportation was not available, RR's family member could have arranged the transportation in the first place and avoided wasting time and | F 745 | | |

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| F 745 | Continued From page 4<br>frustration.<br><br>In an interview on 4/12/23 at 12:53 p.m., the Social Service Assistant (SSA), in the presence of Licensed Nurse, (LN) 1, and the Director of Nursing (DON), stated she arranged the transportation service and received the confirmation from them for Resident 1's 3/20/23 appointment; however, the transportation did not show up that day. LN 1 stated she received a call from RR on 3/20/23 that she was waiting for Resident 1 at the doctor's office. LN 1 stated the facility attempted but was not able to provide a transportation for the 2:20 p.m. appointment due to a short notice. LN 1 stated RR wanted to keep the appointment that day instead of rescheduling the appointment and RR offered the ride for the resident when the facility was not able to arrange the transportation. The SSA stated RR's family member came to the facility and picked up the resident and brought her back to the facility.<br><br>Review of Resident 1's clinical record included a late entry, timed 4/12/23 at 2:39 p.m., Order Details, "Late entry for appointment on 3/20/23 at 11-11:30 am for PCP [Primary Care Provider] ...Appointment rescheduled for 2:30 pm..."<br><br>In a telephone interview on 4/17/23 at 11:05 a.m., RR reported on 4/12/23 Resident 1 had a podiatry appointment outside the facility at 1:30 p.m. and the facility failed again to bring the resident for the appointment in time. RR stated she waited for Resident 1 at the podiatry clinic; however, Resident 1 did not show for the appointment. RR called the facility and was told Resident 1 was still in the facility and the facility was investigating what was going on with the transportation services. RR stated then the podiatry clinic | F 745 | | |

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| F 745 | Continued From page 5<br>clarified that the facility sent a wrong resident for Resident 1's appointment. RR stated she witnessed the resident who was brought in was not able to identify her own name. RR stated the transportation service took the resident back and brought Resident 1 to the clinic around 3 p.m. RR voiced, "That's unacceptable."<br><br>Review of the facility's November 2012 policy and procedure, Transporting Residents to Appointments (Non-Emergency), stipulated, "Resident will be transported to appointments at an off site location in a safe manner, and will be provided assistance if needed to meet the individual needs of the resident..." The procedure instructed the facility staff to give paper work to the transporting person, "The Licensed Nurse or Social Worker will have necessary paper work ready in an envelope, to give to the transporting staff to accompany Residents to the appointment..."<br><br>In an interview on 4/18/23 at 12:42 p.m., the SSA, in the presence of DON, stated the transportation services took a "wrong resident" to the podiatry appointment on 4/12/23 for Resident 1. The SSA stated the resident, who was taken to the podiatry clinic, was at the lobby waiting for her dialysis van when the transportation services inadvertently picked her up instead of Resident 1. The SSA stated the transportation services should have asked staff to identify the resident as well as should have checked the paper work. The SSA explained the resident who was transported to the podiatrist was intellectually delayed and "definitely" needed supervision. The SSA acknowledged the facility should have supervised the pick up and stated staff should have stopped the driver picking up the wrong resident. | F 745 | | |

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| F 745 | Continued From page 6<br><br>Review of Resident 1's clinical record, Social Services Progress Notes, included a late entry dated 4/18/23 at 2:51 p.m., indicated, "Resident was scheduled to have a podiatry appointment on 4/12/23. The transportation company was supposed to pick up resident at 1:00 PM for her 1:30 appointment at..." | F 745 | | |