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

PRINTED: 11/29/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTIÓN	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	' '	LE CONSTRUCTION		E SURVEY PLETED
e				 , : ·		c
		555613	B. WING		11/2	27/2017
NAME OF F	PROVIDER OR SUPPLIER	·	ı	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRO	OVE CARE AND WEL	LNESS		1401 LEMON STREET RIVERSIDE, CA 92501		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N .	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX · TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 000	This document will serve as a credible allegation of our intent to correct deficient practices identified.).
: ·	California Departme	cts the findings of the ent of Public Health during an rd survey to investigate a	-	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provid of the truth of the facts alleged or conclusions set forth on the Statement	er	
	Complaint number: Representing the C Health: Surveyor 34	alifornia Department of Public		Deficiencies. This Plan of Correction prepared and/or executed solely becault is required by the provisions of Heal and Safety Code.	ışe : .	
	complaint investiga the findings of a full	limited to the specific ted and does not represent inspection of the facility.		77.1 m	17 DEC 11,	
F 315 SS=D	number: CA005520 NO CATHETER, PI BLADDER CFR(s): 483.25(e)(013 REVENT UTI, RESTORE	F 315	F 315 How corrective action(s) will be accomplished for those residents found have been affected by the deficient practice;	PH 3: 20	12/26/17
· -	continent of bladde receives services a	t ensure that resident who is rand bowel on admission and assistance to maintain.	· -	Resident A discharged from the facility 9/6/2017.	o n	
, ,		nis or her clinical condition is nat continence is not possible	1	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		
		ith urinary incontinence, based imprehensive assessment, the that-	1	All residents have the potential to be affected by the identified practice.	·	
	indwelling catheter	inters the facility without an is not catheterized unless the condition demonstrates that necessary;		What measures will be put into place of what systemic changes the facility will make to ensure that the deficient praction does not recur;		
F	ļ	<i>a</i>		<u> </u>		
LABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESEMATIVE'S SIGN	NATURE	TITLE		(X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HS5L11

Facility ID: CA240000095

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DEPARTMENT OF HEALTH AND HULL IN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G		E SURVEY PLETED
		555613	B. WING _	·		C 27/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	21/2011
		f		3401 LEMON STREET		
THE GRO	OVE CARE AND WEL	LNESS		RIVERSIDE, CA 92501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC_IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 315	(ii) A resident who indwelling catheter is assessed for reras possible unless demonstrates that and (iii) A resident who receives appropriate prevent urinary tracontinence to the continence to the continence to the continent of bow treatment and send bowel function as This REQUIREME by: Based on interview failed to ensure the policy and procedu (fluid intake and urione of four sample universe of 34 when volume of output ficatheter (a thin stepladder to drain urions failure had the	enters the facility with an or subsequently receives one moval of the catheter as soon the resident's clinical condition catheterization is necessary is incontinent of bladder the treatment and services to cottinections and to restore extent possible. with fecal incontinence, based comprehensive assessment, the exthat a resident who is el receives appropriate vices to restore as much normal	F 31	DSD inservice to licensed staff on proposition of I&O will be conduct on 12/15/2017. Medical Records Director (MRD) will conduct regular audits on I&O documentation completion. How the facility plans to monitor its performance to make sure that solution are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The Pris integrated into the quality assurance system; Results of the audits conducted by MR will be discussed in QA/QAPI meeting least quarterly.	ed	
	unannounced visit	2017, at 8:50 a.m., an was made to the facility for the complaint regarding quality care				

. DEPARTMENT OF HEALTH AND HUMANN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION			SURVEY PLETED
	•	EEE010.	B. WING			ंदर	1	
		555613	B. WING _		<u></u>	<u> </u>	11/2	27/2017
NAME OF	PROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE,	ZIP CODE		
THE GRO	OVE CARE AND WEL	INFSS			D1 LEMON STREET			
''				R۱۱	VERSIDE, CA 92501			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN O	F CORRECTIO	V	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		(EACH CORRECTIVE AS CROSS-REFERENCED TO			COMPLETION DATE
TAG	REGULATION ON L	1	TAG		DEFICIE		TIAIC	· · · •
			-	+	·.		1	•
F 315	Continued From po	200		-	*		·	
1 019,	*	iye z	F;31	וכו		•	ı	
	and treatment.		!			,	1	
<u> </u>		T	;				1	
	On Sentember 12	2017, a review of Resident A's		.			· 1	-
1		ord was conducted. Resident	'	'			1	
1		the facility on July 19, 2017,	l 1			Þi	. 1	1
		t included acute osteomyelitis				.	1	
'		ction in bone), pressure ulcer	;					
 		e skin and underlying tissue	1,				1	· `
		aches into muscle and bone),	1					· -
a	paraplegia (paralys	is of the legs and lower body),	'				! .	
		function of the bladder (lack of	'		•			
		ehydration, and gastroenteritis	• ;			1	1	
l i		nation of the stomach or	1,				i	
ľ	intestine due to infe	ection).	. ;				.	,
	:		, ,				!	
	Δ review of Reside	nt A's facility, "History and	,			•	1	
[dated July 20, 2017, failed to					i	
[1		ent had capacity to understand	1			'		7
	and make decision		.:			-	77	
l.	1	•	'.		•		ιη ' . .	15
l i e			١,		•			3/0
		t A's document titled,			•	7 7 14 7 7 71 = 1		1
'		for Life Sustaining Treatment,"	· ·	.		<i>رى</i> س	<u>਼ਰੂ</u>	r
		y 20, 2017, indicated, "Attempt					خة. ا	
		," (lifesaving technique used in	1			<u> </u>	, ယူ	
		breathing or heartbeat have			4	-1.	20	
		LST further indicated that		İ	•	, .	1	
],	1	ns were to include, "Full					1	
I.	medically effective	goal of prolonging life by all		.			i i	
Ľ	medically effective	means.				•	1	
					•		1	
'	Review of Residen	t A's facility document titled,			•			
		Report," dated August 31, 2017,					1	
		dated July 19, 2017, for an			•		ι	
,		THETER 16FR (French- size			•			
	1	ubic centimeter) BALLON		ļ				i

DEPARTMENT OF HEALTH AND HU.... 1 SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

CTION	(X1) PHOVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION S		E SURVEY IPLETED
	555613	B. WING		1	C 27/2017
•	LNESS		3401 LEMON STREET		21/2011
CH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	COMPLETION DATE
ED DRAINA() RELATED I (lower and I." review of R found no do est was mad entation of F of the reside and received eview of the f ined that the	GE SYSTEM SECONDARY TO STAGE 4 TO RIGHT back part of the hip bone) as esident A's facility medical cumentation of intake or e to the facility for lesident A's intake and output. ent's intake was faxed by the d on September 13, 2017. faxed documentation it was are was no output	F ₁ 315			
to the facility entation for I interview wa et nurse (MC ly mandated was asked all enting outpuer. The MDS have been'out. The MDS normal procesoley cathete urse stated, thut the entiror output documents or output documents.	r to again request output Resident A. At that time a s conducted with the Minimum DS) (a nurse who conducts assessments). The MDS bout the facility's policy for t for a Resident with a Foley in nurse stated that there output documented for the nurse further stated that it ess especially for residents er to document output. The "We have to monitor intake the stay." A request was made cumentation.			.17 hmg 11, Pt. 3: 20	
	SUMMARY STACH DEFICIENCY OR L. SUMMARY STACH DEFICIENCY OR L. SUMMARY STACH DEFICIENCY OR L. LIED TO BELATED M. (lower and i." Treview of R. found no do dest was madentation of F. of the reside and received eview of the fined that the entation sentent of the facility entation for lied that the entation of the facility entation for lied that the entation sentent of lied that the entation of lied th	SEAND WELLNESS SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL BULATORY OR LSC IDENTIFYING INFORMATION) LIED FROM PAGE 3 ED DRAINAGE SYSTEM SECONDARY E) RELATED TO STAGE 4 TO RIGHT M (lower and back part of the hip bone) as i." Treview of Resident A's facility medical found no documentation of intake or	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL TAG JULIATORY OR LSC IDENTIFYING INFORMATION) JULIATORY OR LSC IDENTIFY INFORMATION) JULIATORY OR STATEMENT INFORMATION) JULIATORY OR STATEMENT INFORMATION) J	STREET ADDRESS, CITY, STATE, ZIP COD 3401 LEMON STREET RIVERSIDE, CA 92501 SUMMARY STATEMENT OF DEFICIENCIES CHOPPICENCY WIST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) JUD THE APPL JUD THE APPL JED THE ATE DO TO STAGE 4 TO RIGHT A (lower and back part of the hip bone) as 1." The review of Resident A's facility medical found no documentation of intake or Jest was made to the facility for entation of Resident A's intake and output, of the resident's intake was faxed by the and received on September 13, 2017, view of the faxed documentation it was ined that there was no output entation sent as had been requested. Determber 14, 2017, at 11:10 a.m., a call was to the facility to again request output entation for Resident A. At that time a interview was conducted with the Minimum et nurse (MDS) (a nurse who conducts by mandated assessments). The MDS was asked about the facility's policy for enting output for a Resident with a Foley ent. The MDS nurse stated that there have been output documented for the tt. The MDS nurse stated that there have been output documented or the turner stay." A request was made or output documentation.	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 LEMON STREET RIVERSIDE, CA 92501 STREET ADDRESS, CITY, STATE, ZIP CODE 3401 LEMON STREET RIVERSIDE, CA 92501 PROVIDERS PLAN OF CORRECTION (EACH CORRECTION MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) JEED FROM DEPICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) JEED TO BRAINAGE SYSTEM SECONDARY 3 INFORMATION JEED TO STAGE 4 TO RIGHT A (lower and back part of the hip bone) as 1. To review of Resident A's facility for entation of Resident A's intake and output, of the resident's intake was faxed by the and received on September 13, 2017, wiew of the faxed documentation it was ined that there was no output entation sent as had been request output, entation for Resident A. At that time a interview was conducted with the Minimum et nurse (MDS) (a nurse who conducts by mandated assessments). The MDS was asked about the facility so picy for enting output for a Resident with a Foley are. The MDS nurse stated that there have been output documented for the int. The MDS nurse further stated that it normal process especially for residents colley catheter to document output. The urse stated, "We have to monitor intake to routput documentation.

. DEPARTMENT OF HEALTH AND HL.... ... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	Į.	COMPLETED
NAME OF PROVIDER OR SUPPLIER THE GROVE CARE AND WELLNESS STREET ADDRESS, CITY, STATE, ZIP CODE 3401 LEMON STREET RIVERSIDE, CA 92501 CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 315 Continued From page 4 received from the facility and reviewed on September 15, 2017. No documentation of			555613	B. WING		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 315. Continued From page 4 received from the facility and reviewed on September 15, 2017. No documentation of		•	LNESS	:	3401 LEMON STREET	
received from the facility and reviewed on September 15, 2017. No documentation of	PREFIX .	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION DATE
	F 50 = D (3 () s fa o T b E	Don September 19, 201 butput was found. On September 19, 201 butput was found. On September 19, 201 butput was conducted to a comput the facility of the facility policy are the facility policy are been recorded butput Documental andicated, "It is the policy are been recorded at the endicated and output (I ecorded at the endicated)." ADMINISTRATION OFR(s): 483.50(a) (a) Laboratory Services to meet the acility is responsible of the services. This REQUIREMENTS. Based on interview	acility and reviewed on 7. No documentation of 2017, at 11:02 a.m., a phone acted with the facility's and Director of Nursing d DON were asked about on for Resident A. The DON ty was "informally" atput. The DON was asked if policy. The DON stated that y intake and output should d. Ty policy titled, "Intake & tion," revised May 2007, policy of this facility that fluid hall be recorded for each welling Foley catheter2. The &O information is to be of each shift by a licensed of each shift by a licensed to provide or obtain laboratory eneeds of its residents. The e for the quality and timeliness with its not met as evidenced and record review the facility and record review the facility	F 502	F 502 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident A discharged from the facility on 9/6/2017 date How the facility will identify other	ب ا

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	'A. BUILDING	LE CONSTRUCTION	COMPLE	
	•	555613	B. WING		11/27/	/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8401 LEMON STREET RIVERSIDE, CA 92501	, , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE C	(X5) COMPLETION DATE
F 502	on the date ordere four sampled resid of 34. This failure	d by the physician for one of lents (Resident A) in a universe had the potential to negatively	F 502	affected by the same deficient practic and what corrective action will be take All residents have the potential to be affected by the identified practice.		
	Findings:	I well-being of the resident.		What measures will be put into place what systemic changes the facility wi make to ensure that the deficient pradoes not recur;	$H = \{$	
	unannounced visit investigation of a cand treatment. On September 12 facility medical red A was admitted to with diagnoses that of right femur (infestage 4 (injury to that is deep and reparaplegia (paraly neuromuscular dy bladder control), dand colitis (inflamintestine due to interpretation)			DON inservice licensed staff on 12/14 regarding 24 hour chart check to audit follow through of physician orders. MRD will conduct regular audits of licensed staff 24 hour chart check of physician orders. How the facility plans to monitor its performance to make sure that soluti are sustained. This plan must be implemented, and the corrective active valuated for its effectiveness. The his integrated into the quality assurant system; Results of the audits conducted by Moof the licensed staff physician order completed audits will be discussed in QA/QAPI meeting at least quarterly.	ions on POC ce	
	physician order da p.m., that indicate (Clostridium diffici caused by the bac	nt A's facility record found a sted August 26, 2017, at 1:19 d, "Stool culture for cdiff le- inflammation of the colon steria) one time only for cdiff sic) 23:59 Stool culture."				·
•		y progress note for Resident A, 2017, at 2:53 p.m., indicated,			17 1	

DEPARTMENT OF HEALTH AND HU....... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION		COMP	SURVEY PLETED
ı		555613	B. WING		·	11/2	27/2017
ı	PROVIDER OR SUPPLIER OVE CARE AND WEL	LNESS	3	STREET ADDRESS, CITY, STATE 1401 LEMON STREET RIVERSIDE, CA 92501	, ZIP CODE	11/2	.172017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BI D THE APPROPRIA		(X5) COMPLETION DATE
F 502	"patient still havir pending stool sam	age 6 ng loose stools, doctor notified ble on 8/28/2017. Still (sic) on lutions for c-diff pending stool	F _. 502				
,	dated August 26, 2 "Patietn (sic) is sta treatment for c.diff. continued lose (sic C.diff. Physician no Stool culture for cd 08/27/2017, 23:59 contact precaution	progress note for Resident A, 017, at 3:36 p.m., indicated, tus post antbiotic (sic) Patient is noted to have stool consitent (sic) with stifled and orders given for: iff one time only for cdiff until Stool culture (sic) Continue s until stool culture results are e: 8/27/2017. End Date:			; ; ;		
•	found a progress n 2:39 p.m., that indi Review of a facility dated August 27, 2 "patient continue for c-diff pending s No documentation the stool culture ha	resident A's facility record ote dated August 27, 2017, at cated no stool was collected. progress note for Resident A, 017, at 3:43 p.m., indicated, s on strict contact precautions tool sample" was found that indicated why id not been obtained on August ed by the physician.	de la companya de la			אס טבר (יו' איז 3: 50	ρ·τί το.
	dated August 29, 2	progress note for Resident A, 017, at 1:03 p.m., indicated, es) episode of loose stool					u.

DEPARTMENT OF HEALTH AND HU. I SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		(X3) DATE COMF	PLETED
		555613	B. WING		,	_	, 7/2017
	PROVIDER OR SUPPLIER OVE CARE AND WEL	LNESS	340	REET ADDRESS, CITY, STATE, D1 LEMON STREET VERSIDE, CA 92501	ZIP CODE	,-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 50 <u>2</u>	Continued From pa	age 7	F 502		į	- -	-
, !	"Diagnostic Labora	ent A's facility document titled, tories & Radiology," indicated n was collected on August 30,					
	dated August 30, 2 "Reported C-diff st	progress note for Resident A, 017, at 3:47 p.m., indicated, ool sample to MD (doctor). or C-diff at this time"		,		. 1	-
	note that indicated	ew found no facility progress when the actual stool sample or why it had not been done 7, as ordered.					
	concurrent intervier conducted with the (DON). The DON physician's order for collected on August lab documentation done until August 3 was the facility's proorder and if an order on August 27 The DON nodded	2017, at 1:38 p.m., a w and record review were facility's Director of Nursing was provided a copy of the or the stool sample to be at 27, 2017, and provided the that indicated it had not been 30th. The DON was asked if it blicy to follow a physician's er had called for a lab to be 7th should it have been done. stated, "Uh huh."				17 pro 14 Pri 3:	0 4 0
	Order, Transcribing indicated, "7. Lat Laboratory reques	g," revised May 2007, o orders are transferred to the t computer and physician's b orders will be verified by Unit				20	

DEPARTMENT OF HEALTH AND HU. __I SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		555613	B. WING		1	Č
NAME OF I	PROVIDER OR SUPPLIER	353013		STORET ADDRESS CITY STATE 710 CORE	11/	27/2017
I NAME OF	-HOVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRO	OVE CARE AND WEL	LNESS		3401 LEMON STREET RIVERSIDE, CA 92501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 502	Continued From pa	ae 8	F; 502		ı	
:	Nurse Manager. A Nursing Notes whe	Il labs are to be charted in n drawn, including site where Il new orders are to be	!	F 514 How corrective action(s) will be		12/26/17
F 514 SS=D	RES RECORDS-COMP LE	LETE/ACCURATE/ACCESSIB	F,514	accomplished for those residents found have been affected by the deficient practice;	to .	u .
ı	CFR(s): 483.70(i)(1 (i) Medical records. (1) In accordance v			Resident A discharged from the facility of 9/6/2017 date How the facility will identify other	o n	-
I		tices, the facility must ecords on each resident that	.	residents having the potential to be affected by the same deficient practice and what corrective action will be taken		·
	(i) Complete;		,	All residents have the potential to be affected by the identified practice.	! !	- :
	(ii) Accurately docu		. ,	What measures will be put into place or what systemic changes the facility will	i	
	(iv) Systematically of	organized	i	make to ensure that the deficient practi does not recur;	ce '	,
	(5) The medical red			DSD inservice to licensed staff on 12/20/2017 regarding accurately	ek	
		ation to identify the resident;		monitoring vital signs and notification o change of condition to physician.	ל טרו	، د َ
	(iii) The compreher	resident's assessments; nsive plan of care and services		DSD inservice to licensed staff on 12/20/2017 in regards to accurate and complete documentation.	3 4	beat be
	and resident review determinations con	ducted by the State;		MRD will conduct regular audits of change of condition notification and of tocomplete and accurate medical record documentation by licensed staff.	P!4 3: 20	1. 1.,
	professional's prog	se's, and other licensed ress notes; and		How the facility plans to monitor its performance to make sure that solution	ıs	

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

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		COMPLETED
		,		•		C
NAME OF F	PROVIDER OR SUPPLIER	555613	B. WING _	STREET ADDRESS, CITY, STATE	F ZIP CODE .	11/27/2017
	OVE CARE AND WEL	LNESS		3401 LEMON STREET RIVERSIDE, CA 92501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 514	(vi) Laboratory, rad services reports as	iology and other diagnostic required under \$483.50. NT is not met as evidenced	, F 51	are sustained. This plan implemented, and the cor evaluated for its effective is integrated into the quasystem; Results of the audits cond	rective action ness. The POC lity assurance	
, 	Based on interview failed to maintain c records for one of t	v and record review the facility omplete and accurate clinical our sampled residents niverse of 34, when:		of change of condition no complete and accurate lice documentation will be dis QAPI/QA meeting at leas	tification and the ensed staff cussed in the	12
	120/80) had been o	sure of 98/61 (average is documented for three without being rechecked or cy;	1			777
	79/58 and no docu indicated it had bee	e had been documented as mentation had been made that en rechecked for accuracy or had been notified for a change			,	
!	and underlying tiss documented on fact sacrococcyx (tailbo	ressure ulcer (injury to the skin ue) was inaccurately cility medical records as a one) wound instead of a right back part of the hip) wound;	v t			
	missing documenta	reatment record (TAR) had ation that indicated treatments ordered by the physician; and				3 2 3
	physician ordered	issing documentation for monitoring of the indwelling rile tube inserted into the ine).				20
	Findings:					

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

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILE			CTION			СОМ	PLETED
		555613	B. WING	i					1	C 2 7/201 7
	PROVIDER OR SUPPLIER		<u> </u>	34	01 <u>,</u> LEMON		STAȚE, ZIP CO	DDE	1 _ • • • •	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EA	CH CORREC S-REFEREN	PLAN OF COR TIVE ACTION CED TO THE A EFICIENCY)	SHOULE) BE	(X5) COMPLETION DATE
F 514	unannounced visit investigation of a cand treatment. On September 12 facility medical red A was admitted to with diagnoses the of right femur (infestage 4 (injury to that is deep and reparaplegia (paraly neuromuscular dy bladder control), dand colitis (inflamintestine due to infestine due to infestine due to infestine due to infestine diagnoses: chr. A review of Reside Physicals," (H&P) indicate if the resident make decisio "DIAGNOSIS: chr. R (right) ischium	2017, at 8:50 a.m., an was made to the facility for the complaint regarding quality care 2017, a review of Resident A's cord was conducted. Resident the facility on July 19, 2017, at included acute osteomyelitis action in bone), pressure ulcer he skin and underlying tissue eaches into muscle and bone), sis of the legs and lower body), sfunction of the bladder (lack of ehydration, and gastroenteritis mation of the stomach or fection). Pent A's facility, "History and dated July 20, 2017, failed to dent had capacity to understand ins. The H&P further indicated, onic decubular (pressure ulcer)."		514					17 DEC 14 PM	
i ·	"VITAL SIGNS: 8/9/2017 (sic) 14: (right)/arm" The	017, at 2:01 p.m., indicated, BP (blood pressure) 98/61- 02 (2:02 p.m.) Position: Sitting r are was no documentation found low BP was rechecked.					*	::57 -	3:20	7
		y progress note for Resident A, 2017, at 4:03 p.m., indicated,						٠	1	

DEPARTMENT OF HEALTH AND HU.... N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES . OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	•	СОМ	E SURVEY PLETED
	•	555613	B. WING			•.	l .	C 2 7/2017
	PROVIDER OR SUPPLIER	LNESS		STREET ADDRESS, CITY, STATE, ZIP COI 3401 LEMON STREET RIVERSIDE, CA 92501			<u>. </u>	27/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 514	"VITAL SIGNS: E Position: Sitting r/a documentation fou was rechecked. Review of a facility dated August 11, 2 "VITAL SIGNS: E Position: Sitting r/a documentation fou was rechecked. Review of a facility dated August 24, 2	P 98/61- 8/9/2017 (sic) 14:02 rm" There was no not that indicated the low BP progress note for Resident A, 017, at 4:15 p.m., indicated, P 98/61- 8/9/2017 (sic) 14:02 rm" There was no not that indicated the low BP progress note for Resident A, 017, at 11:33 p.m., indicated,		514				
	pulse 69 (sic) resp There was no docu the extremely low to physician had beer condition. Review of Residen "ORDER SUMMAR 31, 2017, indicated FOUR TO SACRO CLEANER, PAT DI (negative-pressure	emp (temperature) 98.3 (sic) (respirations) 18 (sic) 79/58" mentation found that indicated BP was rechecked or that the notified of a change in the A's facility record titled, RY REPORT," dated August an order to, "CLEAN STAGE COCCYX WITH WOUND RY AND APPLY NPWT wound therapy) Q3 (every 3)					17 prg 14	ن يان عدد
	Review of Residen of 2017, indicated, SACROCOCCYX PAT DRY AND API	as needed), REASSESS X 21 very 3 days (sic) every 3 days. t A's TAR for July and August "CLEAN STAGE FOUR TO WITH WOUND CLEANER, PLY NPWT Q3 DAYS AND X 21 DAYS every 3 days (sic)	n ,		•		ри 3: 20 -	שבנין ייי

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED C		
	,	555613	B. WING				27/2017		
	PROVIDER OR SUPPLIER OVE CARE AND WEI			340	REET ADDRESS, CITY, STATE, ZIP CODE IN LEMON STREET VERSIDE, CA 92501	,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 514	every 3 days." Further review of Fof August 2017, for physician ordered for Monday August TAR indicated the performed as order initiated date of August The care plan furth "InterventionsAd and monitor for eff Review of Resider "ORDER SUMMA"	Resident A's TAR for the month und blank boxes for the treatments to the sacrococcyx to 7th, Wednesday August 16th, 25th. The blank boxes on the treatments had not been used. In A's facility care plan with an gust 23, 2017, indicated, ure ulcer of Right Ischium"	F	514					
	"INDWELLING CAMONITORING Q (and symptoms) OF FEVER" Review of Resider 2017, found blank ordered monitoring Thursday July 27th These blanks indicates in July.					17 rec 14 PH 3: 20	ال تعربا ،		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
							С		
	<u>. </u>	555613	B. WING			11/	27/2017		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
THE OD	OVE OADE AND MEI	LNEGO	j	34	401 LEMON STREET	•			
THE GROVE CARE AND WELLNESS				R	RIVERSIDE, CA 92501		-		
(X4) 1D		ATEMENT OF DEFICIENCIES	OI D		PROVIDER'S PLAN OF CORRECTION	N	(X5)		
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	X	(EACH CORRECTIVE ACTION SHOULD		COMPLÉTION DATE		
TAG	nedolatori on L	de identifiting information)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	NAIE	DAIE,		
			 						
F 514	Cantinual Frame -	40							
F314	1		F _, 5	14		1			
!		d blank boxes for the physician				'	-		
} -		on August 5th, 6th and 15th	;		,				
		shift, August 18th for the PM	!	1		-			
)		4th and 25th NOC shift .				,			
,		ated the resident's catheter			•	,			
1	1 1	tored as ordered on those six	!			,			
ı	dates in August.	. i	'			,			
 						· i	-		
		4 A la TAD fan Ala 4 5 '				· 1	-		
<u>'</u>		t A's TAR for the month of	'		,				
j i		ound a blank box for the	i						
1		monitoring on the PM shift of	,						
1		er 2, 2017. This blank ent's catheter had not been				1			
		red on that one date in	1		•	1			
'	September.	ed on that one date in				1	1,		
!	Ceptember.					,			
,		i				ļ			
F	On September 12.	2017, at 1:38 p.m., an							
1		ucted with the Director of				İ			
		ne DON was asked about	,			1			
1		pressure that had been				F			
h I		/58 on August 24, 2017. The				I			
. !		e documentation was most					•		
	likely a "typo." (mis	take made in typed or printed			· ·	7	<u> </u>		
	text)				, .	Ä	-		
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		2017, at 3:51 p.m., a phone			7161	1	3		
	1	ucted with the author of the			(18년 - 18년 - 1	P :	4		
[,		ess note that had documented		.	ás.	ယ္ပ	4		
		ood pressure of 79/58. The					•		
		documentation "must have				20			
	been a typo."								
	On Contombas 40	2017 of 11:00 c =				,			
		2017, at 11:02 a.m., a phone ucted with the facility's							
		and DON. The AD and DON							
I	i animadado (AD)	and DOM. THOMD AND DOM	i	- 1			1		

DÉPÀRTMENT OF HEALTH AND HEALTH SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		(X3) DATE SURVEY COMPLETED					
555613				-		C 11/27/2017				
NAME OF PROVIDER OR SUPPLIER				B. WING 11/27/2017 STREET ADDRESS, CITY, STATE, ZIP CODE						
THE GR	OVE CARE AND WEL	LNESS	3401 LEMON STREET RIVERSIDE, CA 92501							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 514	were asked about to A's blood pressure days without being that the blood pressure rechecked. The All about the inaccurate resident's pressure the blanks on the Totacility's expectation completeness in the stated that it was endocument accurate and Charting," revisithe policy of this fact account of the residence.	the documentation of Resident as 98/61 for three consecutive rechecked. The DON stated sure should have been and DON were then asked the documentation of the ulcer on facility records, about AR and were asked the for accuracy and e medical record. The DON expected that the staff ely. Ity policy titled, "Documenting sed May 2007, indicated, "It is cility to provide: 1. A complete dent's care, treatment, re, signs, symptoms, etcC.	F	514						
						17 per 11: pi 3: 20	L > 0.1.			

DEPARTMENT OF HEALTH AND HUMAN : //CES - CENTERS FOR MEDICARE & MEDICAID SERVICES

	t		POST-C	ERTI	FICATION	1 RE	VISIT H	EPOF	{ I		٠,
	R/SUPPLIER/C		MULTIPLE CON	STRUCTIO	N			,		DATE	OF REVISIT
555613	CATION NUMBER		A. Building B. Wing	Ψ ,	r	1	·	<i>'</i> ,,	Y2	12/20/	2017 _{Y3}
NAME OF	F FACILITY				STREE	T ADDRESS, C	ITY, STATE	, ZIP CODE		*1	
THE GR	OVE CARE AND) WEL	LNESS				EMON STREET			-	
. 3	* * * * <u></u>					RIVERS	SIDE, CA 92501				
program corrected provision	, to show those of and the date s	deficie uch:co	ncies previously rrective action w	reported o	the Medicare, Monthe CMS-2567 plished. Each dusly shown; on the	7, State eficienc	ment of Deficient of the second of the secon	encies and Ily identifie	Plan of Corre d using either	ction, tha the regul	t have been ation or LSC
İTE	<u></u> -	· i	DATE	ITEM	477		DATE	. ITEM		·	DATE
Y4			/1 Y5 ·	Y4	- 35		. Y5	Y4			Y5 .
ID Prefix	F0315 - 15.	71	Correction ₄	ID Prefix	F0502	1	Correction	ID Prefix	F0514		Correction
·(-)	483.25(e)(1)-(3)		- 	Reg. #	483.50(a)(1)		,	Dog #	483.70(i)(1)(5)		Completed
	-	<u> </u>	Completed '		<u> </u>		Completed 12/20/2017	Reg. # LSC			Completed 12/20/2017
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REVIEWED BY STATE AGENCY (INITIALS)									DATE	8/18	
REVIEWED BY REVIEWED BY			DATE	DATE TITLE DATE							
CMS RO (INITIALS)						WH					
FOLLOWUP TO SURVEY COMPLETED ON 11/27/2017				UNC	CK FOR ANY UN CORRECTED DEF	CORRE	CTED DEFICIEI IES (CMS-2567)	NCIES, WA SENT TO	S A SUMMARY THE FACILITY?		ES 🔲 NO

EVENT ID:

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