STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555164	A. BUILDING _____ B. WING _____	C 01/08/2021

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acceptable POC 5/14/21 BC 5/14/21

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of complaint #CA00711750. Representing the Department of Public Health: Health Facilities Evaluator Nurse 29821 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility	F 000		
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(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §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	F 755		2/15/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/12/2021

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 755	Continued From page 1 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 and record review, the facility failed to acquire and administer pain medications for Resident 1 in accordance with a physician's order. This failure had the potential to cause Resident 1 to experience discomfort which might have been eased by the timely receipt of ordered pain medication. Findings: Review of a day of admission 4:05 p.m., 10/19/20 nurse practitioner progress note indicated Resident 1's diagnoses included chronic pain, fibromyalgia (a disorder causing widespread muscle pain) and a shoulder rotator cuff (group of shoulder joint muscles and tendons) tear. The medical plan of care for the resident's pain was to "Continue analgesics [pain medications] as ordered...." A 10:42 a.m., 10/22/20 physician "Readmission history and physical" also directed, "Continue analgesics as ordered...." Review of Resident 1's physician 10/20/20 "Order Summary Report" reflected the following narcotics: - "Methadone...10 mg [milligrams, a unit of measure]...one time a day for pain for 5 Days...Order Date 10/19/20, Start Date 10/20/10,"	F 755	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of corrections prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. F755 Immediate corrective action for those Residents affected by the deficient practice; Director of Nursing (DON)conducted an audit for Medication Not Administered on 1/17-01/23/2021 and a medication recap was completed. The DON also met with all Licensed Nurses (LN) and in-serviced them on 1/7-2/92021. The in-service included Medications ordered, received and administered timely. Pharmacy Consultant was contacted. Resident was discharged at the time of	

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F 755	Continued From page 2 and - OxyContin...10 mg ([generic name] oxycodone...) Give 2 tablet [sic] two times a day for pain, Order Date 10/19//10, Start Date 10/19/20.." Review of Resident 1's "Medication Administration Record" (MAR) and "Controlled Drug Record" reflected the methadone was received by the facility on 10/22/20. It was not initially administered until 8:13 p.m., 10/22/20, then was given at 9 a.m., 10/23, 8 p.m. on 10/24/20 and 8 p.m. on 10/25/20, for a total of four doses instead of five. At 4:05 p.m., 1/5/20, the Executive Director (ED) indicated the methadone prescription form had been FAXed to the pharmacy on 10/19/20. The form did not include information about Resident 1's diagnosis, however, and "around 10/21" the pharmacy stated the prescription form was invalid. The resident's nurse practitioner clarified the prescription for the pharmacy on 10/22/20 and the medication was then sent to the facility. The ED indicated the facility "only sent 4 pills not 5." Nursing progress notes of 7:44 a.m., 10/20/20, 8:12 a.m., 10/21/20, and 9:44 a.m., 10/22/20 indicated staff were waiting for the methadone to arrive but did not specify any actions taken to expedite delivery. At 12:07 p.m., 1/8/20, the Executive Director indicated there was "no documentation to reflect the calls to pharmacy and doctor" made in efforts to hasten the medication's delivery. Review of Resident 1's MAR and "Controlled	F 755	review. DON checked Electronic Medical Record (EMR) for this resident and the document indicates resident had 0 out of 10 recorded pain. Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action to be taken; Per the above mentioned audit, no other residents were affected. Facility measures and systemic changes to ensure the deficient practice does not recur; Follow up plans based on the LN in-service is to complete a daily audit of medications not given per our EMR to quickly intervene with any pharmacy delay. This audit is being completed by the Health Information Manager (HIM) and Assistant (HIA). DON and/or Assistant DON (ADON) are notified immediately of any discrepancies. Facility plan to monitor corrective actions and sustain compliance; integrate Quality Assessment and Process Improvement (QAPI) Process; The DON will evaluate monthly trends, involve the Pharmacy Consultant and provide the QAPI Committee with any issues or negative trends. The information is reviewed for trends during the monthly QAPI meeting to ensure no negative trends persist and to achieve improvements.	

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F 755	Continued From page 3 Drug Record" indicated the OxyContin was not received by the facility until 10/22/20, but was not started until 9 a.m., 10/23/20. Nursing progress notes of 10 a.m. and 4:58 p.m., 10/20/20, 5:13 p.m., 10/21/20, and 9:43 a.m. and 4:21 p.m., 10/22/20 indicated nursing staff were "awaiting delivery" of the OxyContin from the distributing pharmacy. An 8:11 a.m., 10/21/20 entry noted the nurse was "waiting for meds [medications] to arrive." A 2:07 p.m., 10/22/20 note stated of the OxyContin, "administer when available." At 12:07 p.m., 1/8/20, the Executive Director noted there was "no documentation in [the facility's] records to reflect efforts to get [the] medication." Nursing progress notes of 6:13 a.m., 10/23/20 reflected, "Pt [patient] became agitated stating, 'I can't get anything from this place, no pain medication, no ice pack.' Informed pt that the only available PRN [as needed] pain medication on order is Acetaminophen [Tylenol]...which the pt. received at 2339 [11:39 p.m., 10/22/10]...Pt was also informed that he has an order for scheduled Oxycodone 10 mg 2 tabs Q12h [every 12 hours]. Pt also stated, 'I want to leave, I'll call my wife in the morning.'...." A 10/22/20 care plan set as a goal that Resident 1 "will verbalize adequate relief of pain" and included "Administer analgesia as per orders" as an intervention.	F 755	Note: There are errors on dates in the description of the facts. Top of page 3 states "Days...Order Date 10/19/20, Start Date 10/20/10" The date 10/20/10 should be 10/20/20. Also, "for pain, Order Date 10/19/10, Start Date" the date 10/19/10 should be 10/19/20.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		2/16/21

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F 842	Continued From page 4 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 5 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain a complete and accurate medical record for Resident 1 when: 1) A nursing progress note with discharge details was not found, and 2) Two narcotics were documented as having been given twice when medication orders were renewed, and 3) Conflicting orders regarding the resident's medical decision-making ability were found. This failure resulted in significant information being omitted from Patient 1's medical record,	F 842	F842 Immediate corrective action for those Residents affected by the deficient practice; Director of Nursing (DON) conducted an audit for medications not administered including reason why on 1/17/2021 through 2/9/2021. In-service included, clinical documentation standards, which included preventing and addressing duplicate orders and clinical documentation standards to include	

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F 842	Continued From page 6 which could affect subsequent care decisions by healthcare providers and others relying on the accuracy and completeness of the clinical document. Findings: Review of the medical record demographics summary reflected Resident 1 was admitted to the facility less than three weeks earlier with diagnoses including dementia (a chronic degenerative loss of brain function which can affect memory, thinking, language, judgment and behavior), chronic pain syndrome, and wounds on his legs which required dressing changes. His Medication Administration Record (MAR) indicated he received 11 regularly-scheduled drugs. In an 11:41 a.m., 11/20/20 interview, the Director of Nursing (DON) stated that Resident 1 had been discharged from the facility on 11/5/20 against medical advice (AMA). 1) During a medical record review prompted by allegations of resident care problems, details regarding Resident 1's discharge were not found. A 6:12 p.m., 11/5/20 nursing progress note read, "911 notified of situation. Two staff standing with resident outside. After several encouragement [sic] from staff to resident to sit in the lobby, resident agreed to sit in the lobby "waiting for a ride." Police in building. Instructed resident and wife about [leaving] AMA." A 7:15 p.m., 11/5/20 note from the DON reflected, "...Nursing attempting to redirect him...Nurses instructed to call the wife for assistance to	F 842	discharges, medication administration, and all patient interactions. Pharmacy Consultant was contacted. Resident was discharged at the time of review. The Inter-Disciplinary Team (IDT) completed an audit for designated responsible party and resident capacity. Physician orders for capacity and Durable Power of Attorney were verified and any discrepancies in the EMR were corrected. All pending discharges were reviewed by the IDT and documentation was completed appropriately. Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action to be taken; Per the above mentioned audit, duplicate orders were corrected. There were no negative outcomes for residents. The IDT completed an audit for designated responsible party and resident capacity. Physician orders for capacity and Durable Power of Attorney were verified and any discrepancies in the EMR were corrected. All pending discharges were reviewed by the IDT and documentation was completed appropriately. Facility measures and systemic changes to ensure the deficient practice does not	

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F 842	Continued From page 7 convince him to go back to his new room." The record's final nursing progress notes, entered at 7:38 p.m., 11/5/20, read, "Resident returned from appointment via private care, then transferred to north station" and "Transferred to room 38D nurse [sic] given report and medications." The record did not include written instructions for after-discharge care or indicate the resident or responsible party was advised that post-discharge care planning could be offered at a later time, including wound care and medication administration. A "Discharged Against Medical Advice (AMA)" form was found in the record, signed by a representative of Resident 1 at 7:47 p.m., 11/5/20. In a 1:28 p.m., 12/28/20 interview, the DON was asked if the medical record included details of the discharge including when he left, with whom he left, and his destination. The DON stated the medical record "doesn't say" and added, "The nurse should have written a note saying he left AMA." Review of the facility's August 2001 "LTC [Long Term Care] Health Information Practice and Documentation Guidelines" policy and procedure indicted, "As a standard, a brief narrative note should be written at the time of discharge, including the date and time of discharge, the resident's disposition, condition of the resident at discharge, where discharged to, and the individual taking responsibility for the resident."	F 842	recur; During the monthly Medication Regimen Review, the consultant pharmacist will identify an urgent medication irregularity that requires immediate action. The consultant pharmacist will immediately notify the DON who will contact the attending physician to assist in correction the medication order. The consultant pharmacist will include a summary in the monthly QI report of any duplication of therapy during the next three months. The audit for medications not administered is being completed by the HIM and HIA. DON and/or Assistant DON (ADON) are notified immediately of any discrepancies. DON will evaluate monthly trends, involve the consultant pharmacist and provide the QAPI team with issues. The IDT on admission will identify the Responsible Party and verify physician orders for capacity. If admission records are incomplete this information is obtained. HIM/HIA will review all new admissions and bring to daily team meeting. Any discrepancies will be corrected by contact family, record review, resident interview and/or contacting the physician. The IDT will discuss all pending discharges during the daily IDT meeting. DON and/or designee will ensure nursing	

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F 842	Continued From page 8 The facility's 2006 "Discharge/Transfer of the Resident" procedure indicated the following details were to be documented: "Date, time, individual accompanying resident, ...post-discharge plan of care if resident is discharged to...a lower level of care..., Type of transportation, Whether or not medication was taken by the resident..., Disposition of residents' [sic] belongings... Keep a copy of all forms completed and place in resident's medical record." 2) Review of the October 2020 MAR reflected two orders for the manmade opioid (strong pain medication) methadone to be administered daily. One order was written on 10/19/20 and the second on 10/21/20. The MAR noted that methadone was given both in the morning and in the evening on 10/23/210. Review of the facility's "Controlled Drug Record" for Resident 1's methadone reflected the medication had been administered only once at 9 a.m., 10/23/20, however. At 4:05 p.m., 1/5/21, the Executive Director verified that the methadone had only been given once. Review of the November 2020 MAR reflected two orders for the opioid oxycodone, one from 10/21/20 and the second from 11/4/20. At 5 p.m. on 11/4/20, the medication was documented as having been given associated with each order. During the 1:28, 12/28/20 interview, the DON was asked if the 5 p.m., 11/4/20 oxycodone had been given twice. The DON indicated, "It does look that	F 842	documentation is complete. HIM/HIA and DON and/or designee will present above trends to QAPI team during the meeting. Facility plan to monitor corrective actions and sustain compliance; integrate Quality Assessment and Process Improvement (QAPI) Process; The DON and HIM/HIA will evaluate monthly trends, involve the Pharmacy Consultant and provide the QAPI Committee with any issues or negative trends. The information is reviewed for trends during the monthly QAPI meeting to ensure no negative trends persist and to achieve improvements.	

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F 842	Continued From page 9 way." Review of the facility's "Controlled Drug Record" for Resident 1's oxycodone reflected it had been given only once on 11/4/20 at 4:33 p.m., however. At 4:05 p.m., 1/5/21, the Executive Director noted, "The nurse documented in error that it was given [a second time]." The "LTC [Long Term Care] Health Information Practice and Documentation Guidelines" procedure reflected, "When a physician changes a physician order that is currently in place, the original order must be discontinued first and a new order written that reflects the change." The facility's 2013 "Reordering, Changing and Discontinuing Orders" policy stated, "Any request to change an existing order should be treated by Facility as a new order, with a corresponding cancellation of the previous order." At 4:05 p.m., 1/5/21, the Executive Director indicated, "We do not know why the system did not flag the duplicate order...the nurses are supposed to DC [discontinue] any duplicate order." 3) Review of the November 2020 "Order Summary Report" reflected the following conflicting 10/19/20 medical provider orders: "MD [Medical Doctor] determines that Resident does NOT [capitalized in order] have the Mental Capacity to make Healthcare decisions as per History & Physical [a physician note] or Transfer orders or preferred intensity of care [amount of care wanted by a resident, especially at end-of-life]," and "MD determines that Resident has the Mental	F 842		

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F 842	Continued From page 10 Capacity to make Healthcare decisions as per History & Physical or Transfer orders or preferred intensity of care." At 4:05 p.m., 1/5/21, the Executive Director indicated the existence of the dual orders had been an error. Review of the facility's November 2016 "Promoting the Right of Self-Determination for Healthcare Decisions and Advanced Healthcare Directives" policy reflected, "A physician is responsible for determining the resident's...capacity for making healthcare decisions...Upon admission, staff should document the legal healthcare decision maker for each resident. A resident is always [bold and underlined contained in policy] considered the legal healthcare decision maker unless (a) a court of law has appointed a healthcare guardian or conservator for the resident, (b) a physician has determined and documented that a resident lacks healthcare decision making capacity and/or (c) the resident has designated a surrogate decision maker through an advanced healthcare directive or durable power of attorney for healthcare and the directive is active. An 'active' directive means that the resident has indicated that their designee has immediate decision making authority, even when they retain capacity...The facility will deliver care...based upon the orders provided by the resident's physican in accordance to [sic] the resident/legal healthcare decision maker's expressed treatment wishes." The facility's November 2017 "Discharge Planning Positive Practice" policy read, "It is imperative to check the physician's statement of	F 842		

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F 842	Continued From page 11 capacity before beginning discharge planning...."	F 842		