STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055289	A. BUILDING _____ B. WING _____	C 02/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LODI CREEK POST ACUTE	321 WEST TURNER ROAD LODI, CA 95240

POC Approved 3-2-21 for Christine Douglas

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00702447. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 43071. 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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that services being provided met professional standards of quality when: 1. Resident (RES) 1's medication was resumed without a physician order, which put RES 1 at risk for over medication; 2. RES 1 was given the wrong medication dose, which put RES 1 at risk for over medication; 3. A physician order to check RES 1's blood sugar at bedtime was not carried out, which put RES 1 at risk for high or low blood sugar going undetected; 4. Staff did not follow the physician order to notify	F 658	F000 Preparation and/or execution of this Plan of Correction, inclusive of pages 1 through 9, does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code Section 1280. In response to the Department□s findings, we submit the following Plan of Correction which shall constitute¿Lodi Creek Post-Acute□s credible allegation of	3/15/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/26/2021

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 658	Continued From page 1 the physician of RES 1's low blood sugar level, which put RES 1 at risk for poor outcome related to low blood sugar; 5. Staff did not schedule a follow up appointment with RES 1's primary provider as requested by RES 1's facility provider, which put RES 1 at risk for disruption of care continuity; 6. Facility did not follow up on Registered Dietitian's diet recommendations for RES 1, which put RES 1 at risk for altered nutritional status; and, 7. RES 1's weight was not checked weekly as ordered by the physician which put RES 1 at risk for weight loss and altered nutritional status. Findings: 1. During concurrent record review and interview on 10/08/20, at 1:48 p.m., review of RES 1's physician order dated 8/20/20 indicated, "Hold Sinemet (used to treat symptoms of Parkinson's disease/symptoms such as shakiness, stiffness, difficulty moving) for now." The order did not indicate a resume date for Sinemet. A review of RES 1's Medication Administration Record (MAR) indicated RES 1's Sinemet was resumed on 8/25/20. Licensed Nurse (LN) 1 and Medical Records (MR) stated they were not able find an order to resume RES 1's Sinemet on 8/25/20. LN 1 confirmed that RES 1's Sinemet was resumed on 8/25/20 without a physician's order. LN 1 further stated they have to have a physician's order to resume a medication that was placed on hold by physician. Review of facility policy "Administering	F 658	compliance. F658 □ Services Provided Meet Professional Standards CFR(s): 483.21 (b)(3)(i) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 1 discharged from the facility on 8/28/2020. How the facility will identify other residents having the potential to be affected by the same practice and what corrective action will be taken; On 2/26/2021, the Medical Records Director conducted an audit to include, but not limited to, medication dosages, diabetic orders and parameters, outstanding appointments, and dietary recommendations. The audit was reviewed by the Director of Nursing and Nursing Supervisor for any other residents who may have been affected. None were found. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; On 2/25/2021, the Director of Nursing in-serviced licensed nurses on the necessity to have a physician order for medication and treatment, following the	

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F 658	Continued From page 2 Medications," dated April 2019, indicated, "Medications are administered in accordance with prescriber orders..." 2. During concurrent record review and interview on 10/08/20, at 1:48 p.m., a review of RES 1's physician order dated 8/19/20, indicated a medication order for a 4% Lidocaine (topical pain reliever) patch with instructions to apply half the patch to the right hip and half to the left hip every morning, and remove every night. Review of RES 1's MAR indicated, "Lidocaine Patch 4% apply to left hip topically one time a day ...Lidocaine patch 4% apply to right hip topically one time a day." LN 1 verified that the Lidocaine order was transcribed wrong. LN 1 confirmed that the Lidocaine order was to apply one-half of the patch to the right hip and one-half to the left hip, rather than a whole patch to each hip. Review of MAR indicated RES 1 received the wrong dose of the Lidocaine patch for nine days from 8/19/20 through 8/23/20 and 8/25/20 through 8/28/20. Review of facility policy "Administering Medications "dated April 2019, indicated," Medications are administered in accordance with prescriber orders..." 3. During concurrent record review and interview on 10/08/20, at 1:48 p.m., a review of RES 1's physician order dated 8/13/20, indicated, "Finger Stick Blood Sugar (FSBS) [checking blood sugar level using small amount of blood from fingertip] at bedtime." During review of RES 1's MAR, there was no documented evidence RES 1's blood sugar level were checked at bedtime. LN 1 verified that RES 1's physician order to check her blood sugar level at bedtime daily was not carried out. Review of the MAR indicated RES 1's blood	F 658	physician order and carrying out the order, following the 5 rights of medication administration, including, but not limited to, following California Nursing Practice Act- Scope of Regulation, with an excerpt from Business and Profession Code. 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 POC is integrated into the quality assurance system; The Medical Records director will perform routine diabetic audits to verify that physician□s orders, as well as registered dietician□s recommendations, are being carried out. The Medical Records Director will perform routine audits on pain patches to monitor that the correct dose is being applied. During IDT clinical review with new admissions and/or new orders, follow-up appointments will be monitored so that no appointments are missed. The Medical Records Director will validate during weekly audits that weekly weights are being checked and recorded as ordered by the physician. The QAPI committee will review findings monthly for 3 months and continued if	

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F 658	Continued From page 3 sugar level at bedtime was not checked from 8/13/20 through 8/28/20. Review of RES 1's Nurses Progress Notes dated 8/23/20 timed 9:59 p.m. indicated, "Resident sent out at 9:56 p.m. to hospital for low FSBS of 46...resident was non-responsive." Review of RES 1's "Hospital Emergency Services Discharge Instructions" dated 8/23/20 timed 11:53 p.m. indicated,"...discharge diagnosis hypoglycemia (low blood sugar level) ...follow-up instructions. Check blood sugar three times daily. If blood sugar is low do not give glipizide (oral medication to lower the blood sugar level)." Review of facility policy "Administering Medications "dated April 2019, indicated," Medications are administered in accordance with prescriber orders..." 4. During concurrent interview and record review on 10/22/20 at 11:20 a.m., RES 1's MAR indicated physician order dated 8/14/2020 ".... call MD [Medical Doctor] if blood sugar greater than 400 or less than 70.." Review of MAR indicated RES 1's blood sugar level was 68 on 8/20/20 at 4:30 a.m., 65 on 8/23/2020 at 11:30 a.m. and 4:30 p.m. and 65 on 8/24/20 at 6:30 a.m. There was no documented evidence the MD was notified of RES 1's low blood sugar results. LN 2 and MR stated they could not find the documentation of MD notification. LN 2 stated if it was not documented then it was not done. 5. During a concurrent interview and record review on 10/22/20 at 11:30 a.m., RES 1's physician order dated 8/20/20, indicated,"...Make F/U [Follow up] Appt. [Appointment] with PCP [Primary Care Provider] Dr. .... regarding SINEMET..." There was no record indicating the	F 658	errors are identified.	

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F 658	Continued From page 4 follow up appointment was scheduled. LN 2 and MR stated they were unable to find documentation of any attempts made to schedule follow up appointment with PCP. LN 2 stated they should have scheduled follow up appointment with resident's PCP as facility provider requested. 6. During concurrent interview and record review on 10/22/20 at 11:30 a.m., review of RES 1's record titled,"AWG-AG Dietary (Initial/Annual/SCOC/Readmit)", dated 8/17/2020 indicated dietary recommendations by Registered Dietitian(RD),"Change diet to .....Snack BID [twice a day]....." LN 2 stated nurses follow up on RD recommendations. They notify resident's physician and carry over RD recommendations approved by the physician. LN 2 stated they could not find the documentation if RES 1's RD recommendations dated 8/17/20 were followed up on. LN 2 confirmed if documentation is not there then it was not done. 7. During concurrent interview and record review on 10/22/20 at 11:30 a.m., RES 1's physician order dated 8/13/20, indicated, "Weekly weights..." RES 1's weight record indicated,".....copied from [hospital name]..."LN 2 stated resident weights copied from hospital records was not acceptable. The weight has to be done on their facility scale. LN 2 stated RES 1 should have been weighed at the facility and confirmed RES 1's weekly weight checks were not done as physician ordered. According to California Nursing Practice Act, dated 1/1/2013, indicated, "...Practice of Nursing Defined... direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic	F 658		

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F 658	Continued From page 5 agents.... ordered by and within the scope of licensure of a physician..." https://www.rn.ca.gov/pdfs/regulations/npr-i-15.pdf	F 658		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §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,	F 842		3/15/21

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F 842	Continued From page 6 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. §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, facility failed to ensure accurate documentation of resident's medical records when: 1. Resident (RES) 1's meal intake was not	F 842	F842 □ Resident Records □ Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) How corrective action(s) will be	

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F 842	Continued From page 7 recorded consistently. As a result, RES 1's meal intake record did not accurately reflect whether or not RES 1 actually ate a meal or if he/she ate enough to meet daily dietary needs; 2. Administration of RES 1's medication was not documented in the Medication Administration Record (MAR), which placed RES 1 at risk to miss or overdose medication. Findings: 1. During concurrent interview and record review on 10/8/20, at 12:10 p.m., RES 1's medical record titled, "CNA[Certified Nursing Assistant]-ADL[Activities of Daily living] Tracking Form" dated 08/2020, indicated no documentation of RES 1's dinner intake on 8/14/20, 8/15/20, 8/18/20, 8/19/20, 8/20/20, 8/22/20, 8/23/20 and 8/25/20. Licensed Nurse (LN) 1 confirmed missing documentation of RES 1's meal intakes. LN 1 stated based on available records CNAs were not documenting meal intakes. LN 1 further stated they have issues with registry staff documentation, and they are training them. Review of facility policy "Charting and Documentation" dated July 2017, indicated, "All services provided to the resident....shall be documented in the resident's medical record....Documentation in the medical record will be...complete..." 2. During concurrent interview and record review on 10/22/20, at 11:40 a.m., RES 1's physician order dated 8/24/20, indicated to start Intravenous (IV) fluids (liquid solution given straight into a vein through a drip to replace water, sugar and salt), "D5 [sugar solution] 1/2	F 842	accomplished for those residents found to have been affected by the deficient practice; Resident 1 discharged from the facility on 8/28/2020. How the facility will identify other residents having the potential to be affected by the same practice and what corrective action will be taken; On 2/26/2021, the Medical Records Director conducted an audit to include, but not limited to, medication dosages, diabetic orders and parameters, outstanding appointments, dietary recommendations, and meal intake. The audit was reviewed by the Director of Nursing and Nursing Supervisor for any other residents who may have been affected. None were found. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; On 2/26/2021, the Director of Staff Development re-educated the CNA□s on proper and complete documentation for meal intakes. 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	

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F 842	Continued From page 8 NS [Normal Saline; salt solution] 50 ml/hr. [milliliter per hour] x [times] 2 liters every shift for x 2 liters for 3 Days." No documentation of this order, dated 8/24/20, appeared in RES 1's MAR. LN 2 confirmed the 8/24/20 physician order to start D5 1/2 NS IV was not documented on the MAR. LN 2 further stated, "It's poor documentation, it should have been documented in the MAR." Review of facility policy "Charting and Documentation" dated July 2017, indicated," The following information is to be documented in the resident medical record.....Medications administered.....Documentation of procedures and treatments will include...date and time the procedure was provided...name and title of the individual(s) who provided the care..."	F 842	evaluated for its effectiveness. The POC is integrated into the quality assurance system; The Medical Records Director will validate during routine medication administration audits that medications given are being documented in the resident medical record. The QAPI committee will review findings monthly for 3 months and continued if errors are identified.	