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) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555404	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE VILLAGE HEALTHCARE CENTER	17040 ARNOLD DR. RIVERSIDE, CA 92518

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint Number: CA00776633. Representing the Department: Health Facilities Evaluator Nurse: 41348 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was identified for complaint number: CA00776633.	F 000	This document will serve as a credible allegation of our intent to correct the deficient practice identified. Preparation and/or execution of this Plan of Correction do not constitute admission or agreement, by the provider, of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907	
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights,	F 551	**F551** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 1 was already discharged from the facility at the time of visit from CDPH. Following the complaint visit, the Director of Nursing Services (DNS) reviewed the medical records and verified that Family Member 1 (FM1) was determined to be the decision maker.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: AV VDV — (X6) DATE: 5/31/22

/ 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 551	Continued From page 1 except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the	F 551	**B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?** All residents in the facility are potentially to be affected by the alleged deficient practice as failure to determine the appropriate Durable Power of Attorney for health care decision (DPOA) will result in poor communication between the family and the facility in regard to resident's wishes regarding medical care. The Interdisciplinary Team (IDT) reviewed representative(s) of each resident in the facility, no similar findings noted. **C. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** It is the policy of the facility to ensure that in order to protect and promote the right of each resident, the facility will: (1) check the status of DPOA for Healthcare Decision for each resident and discussed with resident and/or resident's representative upon admission to the facility or as soon as practicable. (2) If the resident has not designated a DPOA, the facility staff will verify with resident representative.	

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F 551	Continued From page 2 representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to determine which family member had designation of durable power of attorney for health care decisions (DPOA-legal decision maker for care), for one of three residents reviewed (Resident 1). This failure had the potential to result in poor communication between the family and the facility and the potential for Resident 1's wishes regarding medical care to not be followed. Findings: On March 14, 2022, the department received a complaint which indicated Resident 1's designation of DPOA was not being honored. On March 23, 2022, at 10:35 a.m., an unannounced visit was conducted at the facility for the investigation of the complaint. On March 23, 2022, a review of Resident 1's facility medical record was conducted. Resident 1 was admitted to the facility on January 7, 2022, with diagnoses which included cerebral infarction (stroke that occurs as a result of disrupted bold flow to the brain) and hypertensive encephalopathy (dysfunction in the brain due to significantly high blood pressure). A review of Resident 1's facility history and physical dated January 8, 2022, indicated	F 551	Director of Nursing Services (DNS) provided in-service to Licensed Nurses on 04/29/22, including the Policy and Procedure on "Resident's Rights" with emphasis given on the the verification and discussion of DPOA with resident and/or resident's representative upon admission or as soon as practicable. Upon admission, the Admitting Nurse (AN) will check and verify the appropriate DPOA or representative. Social Services Director (SSD) will check new admit to the facility and ensure that appropriate DPOA and or representative is identified and verified to ensure that resident's wishes regarding medical care are properly communicated. The Interdisciplinary Team (IDT) will also review and discuss the status of DPOA during the IDT Conference with resident and/or resident's representative. **D. How the facility plans to monitor its performance to make sure that solutions are sustained?** Findings of the SSD, IDT and AN will be provided to DNS. DNS/Designee will monitor for compliance. DNS/Designee will report findings identified to the QAA Committee during the monthly Quality Assurance Performance	

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F 551	Continued From page 3 Resident 1 did not have capacity to understand and make decisions. A review of Resident 1's "Springing Durable General Power of Attorney," dated August 30, 2018, indicated family member (FM) 1 as decision maker and FM 2 as an alternate decision maker. Review of Resident 1's progress note dated January 17, 2022, at 10:46 p.m., indicated, "...Resident admitted s/p (status post) hospitalization for further medical care...Apparently (FM 1) was designated agent and alternate is (FM 2) who is now will be primary decision maker. (FM 1) has been interfering with resident care and hospital ethics committee was consulted on 1/3/22 and recommended for (FM 2) as DPOA...(FM 1) was deemed inappropriate decision maker...(FM 2) will now be primary decision maker..." Review of Resident 1's progress note dated January 19, 2022, at 11:41 p.m., indicated, "... (FM 1) has been coming in to visit...presenting herself the DPOA for health care...indicates she was the designated agent and that (FM 2) is only alternate if she refused and removed self...no documents presented to her that she was revoked as resident DPOAHC (DPOA health care)..." Review of Resident 1's progress note dated January 30, 2022, at 1:04 p.m., indicated, "...Late entry for Friday 1-28-22...Ombudsman in the building...explained everything including previous hospital forming ethics committee who made a decision to removed (sic) (FM 1) to be the decision maker and make (FM 2) to be the	F 551	Improvement meeting for the purpose of process improvement or changes to the plan to ensure substantial compliance with this plan of correction. **Completion Date: 05/31/2022**	

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F 551	Continued From page 4 primary decision maker. Requested fro (sic) advised for the reason that (FM 1) has been interfering with resident care...Only paper work and documents are from hospital SW (social worker) which indicated decision made by ethics committee. Per Ombudsman not really sure if documents apply and how it is in hospital setting...Also last Friday...voice message from (FM 2) received saying that we can allow (FM 1) to visit but not make any decision about resident..." Review of Resident 1's progress note dated February 2, 2022, at 11:55 a.m., indicated, "...(FM 1) here again...wants her Mom out of here 2 days ago and wants dc (discharge) now...Resident does not have the capacity to make medical decision but has been saying that she wants to go home and not wanting to stay here anymore..." Review of Resident 1's progress note dated February 3, 2022, at 4:16 p.m., indicated, "...(FM 1) was here early this morning...mother will be discharge today...DC process started and cleared that (FM 1) has the rights to moved (sic) resident to her previous facility...Receiving facility was notified that resident on her way...(FM 1) following..." On March 23, 2022, an interview was conducted with the Director of Nursing (DON). The DON stated the resident doctors determine when the residents have capacity to make decisions. She stated when the resident did not have capacity, the facility will determine who would make decisions for the residents, starting with immediate family. On March 23, 2022, at 12:15 p.m., an interview	F 551		

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F 551	Continued From page 5	F 551		

and concurrent record review were conducted with Social Services (SS). SS stated Resident 1 was admitted with notes from the general acute care hospital (GACH) which indicated FM 1 was revoked by the GACH Ethics committee as DPOA and FM 2 was acting DPOA for Resident 1. She stated FM 1 was frequently in the facility and stated she was DPOA not FM 2. SS stated Resident 1 wanted to please everyone. She stated Resident 1 would agree to whatever FM 1 or FM 2 wanted. SS stated after the Ombudsman visited and spoke with Resident 1, the facility decided to discharge Resident 1 per Resident 1 and FM 1's wishes.

On March 23, 2022, at 12:45 p.m., a follow-up interview and concurrent record review were conducted with the DON. The DON stated Resident 1's FM came to the facility and stated she was DPOA, not FM 2. The DON stated the facility reached out to FM 2 but he did not respond to their calls after Resident 1 was admitted. She stated after FM 2 failed to return calls FM 1 was recognized as DPOA.

On April 19, 2022, at 10:46 a.m., a telephone interview was conducted with the Administrator (Adm). The Adm stated per the GACH paperwork FM 1 was revoked as the DPOA and FM 2 was the designated DPOA. He stated FM 1 was very upset and wanted Resident 1 discharged immediately. The Adm stated the facility held an ethics meeting 10-14 days after admission, and determined that FM 1 was able to make decisions for Resident 1.

The facility policy titled, "Policy and Procedure on Residents Rights," undated was reviewed. The policy indicated, "...The resident has a right to a

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F 551	Continued From page 6 dignified existence, self-determination, and communication with and access to person and service inside and out the facility. The facility must protect and promote the rights of each resident..."	F 551		