PoC Accepted on Slightly. 8/4 31331

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

PRINTED: 07/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056080	A. BUILDING _____ B. WING _____	R 07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA MEADOWS NURSING CENTER	150 BELLEFONTAINE PASADENA, CA 91105

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{F 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Revisit Survey. Representing the Department of Public Health: Surveyor ID: 31331 Surveyor ID: 36417 Surveyor ID: 36502 Total Resident Census: 120 Total Resident Sample: 14 Highest Scope/Severity: D	{F 000}	F 000 This plan of correction constitutes the facility's credible allegation of compliance for the deficiencies noted. Pasadena Meadows Nursing Center makes its best effort to operate in full compliance with both Federal and State law. Nothing included in this plan of correction is an admission otherwise. Pasadena Meadows Nursing Center has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objections to the merits or form of any allegations contained herein.	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that mistreatment was prevented for one of thirteen sampled residents (Resident 9). For Resident 9, the facility failed to ensure that staff did not close Resident 9's room door against Resident 9's will. This caused Resident 9 to become upset and had the potential for Resident 9 to become isolated and experience a decline in Resident 9's psychosocial wellbeing.	F 224	**F 224** **Corrective action for residents found to have been affected by this deficiency:** reviewing abuse at their monthly meeting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jo Ellen Bauer | Administrator | 8-5-16

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 224	Continued From page 1 Findings: During an interview on 7/19/16 at 1:40 PM, Resident 9 stated the facility staff had closed her room door against her will for 3 occasions. Resident 9 stated she was upset about the staff closing her door against her wishes and stated she had written letters to complain about the mistreatment she experienced. Resident 9 stated in her interview she felt the staff did not care. Resident 9 had two other roommates. During a record review of the facility's investigation, the summary of the facility's findings indicated staff did in fact close Resident 9's room door. Two other roommates who were in the room with Resident 9 were unable to be interviewed. During a review of the nurses notes, it was indicated on 7/1/2016, the date that the allegation occurred, that Resident 9 was complaining of pain at 2 AM and was experiencing an episode of anxiety. Documentation in the clinical record indicated Resident 9 was restless and was yelling. The note also indicated " Encouraged to verbalize feelings and concerns. " Resident 9's Care Plan dated 7/1/16, a care plan indicated "inappropriate yelling/ screaming behavior during the night for yelling "HELP" once private caregiver has left for the day." The care plan indicated that contributing factors included diagnoses of depression, anxiety, and "fear of being alone." An intervention listed included to "listen attentively and provide reassurance. " During a phone interview by the facility with RN 1	F 224	Resident reports of suspected abuse will be reported to the required agencies. Any staff confirmed to be abusive will be terminated and their action will be reported to their board. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Administrator will give a monthly report to QA Committee on any reported abuse. **How the facility will identify other residents having the potential to be affected by the same deficient practice:** There were no other residents affected by the deficient practice as no other resident screams continuously throughout the night	

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F 224	Continued From page 2 on 7/1/16 at 5 PM, RN 1 indicated " RN supervisor stated last night she observed the door closed. It was the charge Nurse (LVN3) who closed the door due to the residents screaming. Unsure how long the door was closed. " Interview also indicated. " She didn ' t want to be left alone. " During a phone interview by the facility with CNA 3 on 7/1/16 at 6:30 PM, CNA 3 stated "Around 3 AM, the door was closed." During a phone interview by the facility with CNA 4 on 7/1/16 after 6:30 PM, the interview indicated " CNA stated she observed the door to room [Resident 9 ' s room] closed before CNA went to lunch (3 am - 3:30 am). " LVN 3 wrote a statement on 7/2/16 indicating Resident 9 "was informed by CN (Charge Nurse) the door needs to be partially closed for few minutes as not to disturb the sleep of other residents. " LVN 3 documented throughout the written statement that the door was "partially closed."	F 224	disturbing other residents. **Measures that will be put into place to ensure that this deficiency does not recur:** On 7/19/16 to 7/21/16, staff was re-in serviced on Facility's Abuse Policy, emphasizing neglect/isolation. Department heads will talk with residents and families and ask questions regarding staff treatment of them or their family member. Residents Council will continue F 281 **Corrective action for residents found to have been affected by this deficiency:**	7/21/16
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have a system in place to ensure that licensed nursing staff will assess the IV site (IV, or intravenous, site is where a	{F 281}	On 7/19/16, Resident 46, IV site was infiltrated on left forearm. RN Supervisor removed and reinserted on the right forearm and properly labelled by ADON and IV solution was labelled with the resident's name, date, time and rate as ordered by MD. MD was notified and without	7/19/16

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{F 281}	Continued From page 3 small tube is placed into the vein with a metal needle to infuse medications or fluids directly into the bloodstream) at least every hour for one of thirteen sampled residents (Resident 46). For Resident 46, the facility failed to assess Resident 46's IV site every hour, which resulted in Resident 46 to develop a complication from therapy known as an infiltration (infiltration of fluids into the surrounding tissues, according to Fulcher and Frazier's Introduction to Intravenous Therapy for Health Professionals, occurs when the device used for insertion of the IV line is displaced from the vein, or fluid leaks from the vein, allowing the fluid to flow into the tissue). The facility's failure to also identify the infiltration by assessing the IV site at least every one hour has the potential to result in serious harm. According to Hadaway in the American Journal of Nursing, an infiltration can have "serious consequences: the patient may need surgical intervention resulting in large scars, experience limitation of function, or even require amputation." Findings: During an observation on 7/19/16 at 9:07 AM, Resident 46 was observed lying in bed, restless and anxious, calling out "grandma." Resident appeared restless and was grimacing. Resident was lying flat on her back in bed. Resident 46 observed to have an IV on her left forearm. There a small amount of blood underneath the transparent covering over the insertion site of the IV. There was no date, time, or initials indicated on the transparent IV covering. Resident 46's left arm was swollen, the skin near the insertion site	{F 281}	new order. Left forearm with IV infiltration was elevated with pillows, offered pain medication and patient refused and monitored continuously by RN Supervisor and no adverse outcome observed. **How the facility will identify other residents having the potential to be affected by the same deficient practice:** On 7/19/16, DON and/or Designee reassessed all residents with order for IV fluids to ensure no other residents were affected. On 7/19/16 – 7/21/16 in-service training was given by the DON to licensed regarding the Facility's Policy & Procedure on IV Therapy	7/19/16 7/21/16

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{F 281}	Continued From page 4 of Resident 46 ' s IV was reddened. Resident 46 was observed pulling at the IV. The IV was connected to tubing that connected to a bag of solution at the top of the IV. The IV solution hanging was D5 1/2 NS (Half Normal Saline with 5% Dextrose, an IV solution prescribed by the physician to re-hydrate Resident 46). There was a manual flow rate device attached to the IV tubing below the bag set for an infusion rate of 75 ml per hour (the amount of fluid that Resident 46 will receive per hour). The IV infusion was not regulated by an automatic pump with an alarm system. There was no label on IV solution bag indicating the date and time the IV solution was hung or who the IV solution belonged to. The tubing clamp near the IV solution bag was clamped. The IV tubing clamp closest to Resident 46 was not clamped. On 7/19/16, at 9:12 AM, CNA 1 who was at the bedside verbalized " Resident was lying on her arm " when asked about the condition of Resident 46's left arm. CNA 1 verbalized " It looks swollen. " On 7/19/16, at 9:15 AM, RN 2 was asked about Resident 46's IV condition. RN 2 stated " I stopped the hydration because the IV site was no good. RN 2 indicated Resident 46 had the IV infusion ordered because of weight loss and poor appetite over the last month. RN 2 entered the room of Resident 46 to observe Resident 46's arm. It was observed RN 2 clamped the IV tubing clamp closest to Resident 46's IV insertion site at this time. RN 2 stated there was no date, time, or initials on the transparent dressing of the IV and indicated it should have it documented on the dressing. RN 2 confirmed there was no label on the IV solution bag and confirmed that it should	{F 281}	**Measures that will be put into place to ensure that this deficiency does not recur:** RN Supervisor's will monitor all IV sites, flow rate as MD ordered, proper labelling of IV bags, dressing sites and documentation every shift. DON and/or Designee will monitor for compliance and report any negative findings to the administrator for review and follow up. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** The DON or Designee will monitor for compliance and	

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{F 281}	Continued From page 5 have been labeled. RN 2 verified the swelling of Resident 46 ' s arm and indicated that it was infiltrated. RN 2 confirmed that Resident 46 was a confused resident. RN 2 indicated that reinforcement may be applied over the IV to protect it with a confused resident. RN confirmed there was no extra reinforcement over the IV site for Resident 46. On 7/19/16, at 09:30, during an interview with RN 2 indicated that the condition of Resident 46 ' s IV site was found by a LVN at 8:25 AM and reported to RN 2 at 8:30 AM. RN 2 indicated that the night shift nurse left at 7:30 AM, RN 2 indicated that she attempted to start a new IV twice and was unsuccessful. RN 2 stated she would endorse a different nurse to start a new IV. RN 2 stated she was not told during report from the night shift that there were any problems with the IV site. RN 2 stated she received the order for an IV infusion for Resident 46 at 3:15 PM on 7/18/16, and the infusion was started by the evening shift nurse on 7/18/16 at 8 PM. On 7/19/16, a review of Resident 46's care plan with RN 2 confirmed the care plan for IV therapy did not have any interventions to indicate when the IV site should be assessed. RN 2 described the IV site "was infiltrated. " It should have been assessed 8 hours according to the " intravenous therapy record-peripheral catheter " form used for Resident 46. The last time the IV was assessed on the form was at midnight. It was documented with [a 1 (indicated problem free)]. The intravenous therapy record form indicated that the IV was assessed at 8 PM and 12 AM. During a review of the Change of Condition Record for Resident 46 for her IV hydration, RN 3	{F 281}	report any negative findings to the Administrator for review and follow up. The DON will report the findings to the UR/QAPI committee monthly for review and follow-up.	

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{F 281}	Continued From page 6 also documented an assessment of the IV site for Resident 46 at 10 PM. There were no problems documented on the Change of Condition Record at this time. During an interview with LVN 2 on 7/19/16 at 10:15 AM, LVN 2 indicated Resident 46 was offered pain medication " about 30 to 45 minutes ago. " During a record review of the Medication Administration Review on 7/19/16 at 10:16 AM, there was no documentation of pain on 7/19/16 for the morning shift. There was no documentation indicating the pain medication was offered or refused. The Medication Administration Record indicated a licensed nurse was at Resident 46's bedside to provide a morning medication at 6:30 AM. There was no documentation the nurse observed or assessed the IV site of Resident 46 at this time. At 10:40 AM, on 7/19/16, a phone interview was conducted with RN 3 who worked the evening shift. RN 3 indicated that the IV site was not infiltrated during her shift. RN 3 was asked how often she checked IV sites and what was assessed for residents who have an IV. RN 3 stated " I will check it every 2 hours for infiltration " and check the saline lock (an IV that does not having anything flowing through it and the tubing is clamped) every shift. At 3:36 PM, on 7/19/16, at the bedside of Resident 46, the resident was observed lying in bed. New IV site was initiated on her right forearm. Right arm was elevated on a pillow. The DON was in the room at this time. The DON confirmed theleft arm was swollen and the IV	{F 281}		

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{F 281}	Continued From page 7 was reddened and should have been elevated with pillow. At 3:41 PM, on 7/19/16, the medical record of Resident 46 was reviewed with the DON at the nursing station. DON confirmed that no new orders were written in the medical record. A care plan for the infiltration was not established at this time. A Change of Condition form was not established at this time. DON confirmed that the initial IV care plan did not reflect how often the IV site should be assessed at this time. DON indicated that the assessment and maintenance of IV ' s are the responsibility of the RN Supervisor. During an interview with RN 2 at 4 PM on 7/19/16, RN 2 stated the MD was called and ordered a treatment protocol per facility policy for the infiltration. RN 2 stated the MD ordered for monitoring of the infiltration and to elevate the effected site with 1 to 2 pillows. RN 2 stated she did not apply any pillows below Resident 46's forearm during her shift. RN 2 confirmed Resident 46's left forearm that was infiltrated was elevated by the DON at 3:41 PM. The infiltrated arm was not elevated for 7 hours since the discovery of the infiltration for Resident 46. RN 2 confirmed that she did not complete the care plan for the infiltration or the change of condition form at the time of the interview. The facility ' s policy/procedure failed to meet current professional standards of practice. The policy/procedure indicated to " observe the site every eight hours and document condition. " For the policy indicated, the facility did not observe and document the site for over eight hours before the infiltration was discovered.	{F 281}		

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{F 281}	Continued From page 8 According to Fundamentals of Nursing by Potter & Perry, indicated IV infusion should be monitored by qualified personnel at least every one hour. The nurse should " observe the client every hour to determine if fluid is infusing correctly. Check if correct amount of solution is infused as prescribed by looking at time tape. Count flow rate or check rate on infusion pump. Check patency of IV catheter or needle. Observe client for signs of discomfort, inspect insertion site for absence of phlebitis (inflammation of the vein), infiltration, or inflammation. Observe client every hour to determine response to therapy (i.e. measure vital signs, conduct post-procedure assessments). According to Fulcher & Frazier ' s Introduction to Intravenous Therapy For Health Professionals, the literature indicated that " the IV site should be observed every hour and the tubing should be secured in a manner as to prevent movement of the tubing and the hub of the cannula (the part of the IV that connects the big IV tubing from the solution bag to the small tube that goes into the blood vessel). " The literature indicates that for an infiltration, " the IV is discontinued and the needle or catheter for infusion is removed. " The literature indicates " the affected limb will need to be elevated and covered with warm compresses or other therapy as ordered by the physician or as directed by the local policies. Observations and actions should be documented, and the IV infusion should be restarted at another site. " The literature indicates " The health care professional has the responsibility of caring for these complications in a timely manner to prevent further trauma to the tissues. "	{F 281}		