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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: CA00807136 Representing the Department: Health Facilities Evaluator Nurse: 36288 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Four deficiencies were identified for complaint number: CA00807136.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to schedule a follow-up appointment related to the left upper extremity (LUE) splint removal in accordance with General Acute Care Hospital 1 ' s (GACH 1 ' s) discharge instructions for one of seven sample residents (Resident 4). This deficient practice had the potential to cause	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	DON	11/15/2022

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 684	Continued From page 1	F 684		

a decline in the resident ' s well-being due to lack of continuity of care.
Findings:

A review of Resident 4 ' s Admission Record indicated the facility initially admitted the resident on 9/2/2022 with multiple diagnoses including motorcycle accident with laceration of muscle, fascia, and tendon (deep cut on the skin and underlying tissues) at left wrist and fracture to the lower end of left ulna and lower end of left radius (broken forearm bone).

A review of Resident 4 ' s medical records titled, "History and Physical, " dated 9/2/2022, indicated the resident had fluctuating capacity to understand and make decisions.

A review of Resident 4 ' s Minimum Data Set (MDS, a standardized resident screening and care-planning tool), dated 9/9/2022, indicated Resident 4 responds adequately to simple, direct communication only and lacks the ability to express ideas and wants. The MDS indicated Resident 4 required extensive assistance with one-person assist with dressing, eating, toilet use, personal hygiene, and bathing.

A review of Resident 4 ' s Nurses Progress Note, dated 9/27/2022, indicated Resident 4 was transferred to GACH 2 emergency room via 911 on 9/27/2022 at 5:23 p.m.

During an interview on 10/13/2022 at 12:36 p.m., Treatment Nurse 1 (TN 1) stated she admitted Resident 4 from GACH 1, but she was not aware of the plan related to the left upper extremity (LUE) splint removal.

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During a telephone interview on 10/18/2022 at 1:10 p.m., Licensed Vocational Nurse 2 (LVN 2) stated Resident 4 ' s splint was supposed to be removed, "around the last few days he was in the facility, " but Resident 4 got sick at the time and the splint was not removed.

During a telephone interview on 10/18/2022 at 4:22 p.m., the Social Services Director (SSD) stated she did not receive any transportation request/s for any medical appointment/s for Resident 4.

During a telephone interview on 10/18/2022 at 4:56 p.m., Registered Nurse 1 (RN 1) stated she could not recall Resident 4 ' s splint site. RN 1 stated she could not recall any appointment scheduled or to be scheduled regarding Resident 4 ' s splint removal upon Resident 4 ' s admission to the facility on 9/2/2022.

During a concurrent telephone interview and record review, on 10/27/2022 at 4:26 p.m., the Director of Nursing (DON) stated upon resident ' s admission to the facility, the admitting registered nurse (in general) must read all the hospital notes to ensure all medical appointments are inputted in the system as physician ' s orders. The admitting registered nurse must schedule the appointment if necessary or if could not be done on the same shift, he/she must endorse reviewing the hospital records and/or arranging medical appointments to the next shift. A review of Resident 4 ' s GACH 1 records and physician ' s orders, the DON stated the admitting nurse/s missed the discharge instructions regarding scheduling a follow-up appointment for the LUE splint removal as no follow-up appointment with the physician was arranged per GACH 1's

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F 684	Continued From page 3 discharge instructions. The DON stated there was no facility policy regarding the admission process, related to reviewing of hospital records and arranging follow-up appointments. A review of Resident 4's records, the following GACH 1 records were also noted: a. Plastic Surgery Progress Note, dated 9/1/2022 - Resident 4 had a left palmar laceration (deep cut on the palm of the hand), approximately 7 centimeters, with exposed underlying structures and transected nerve and artery (direct mechanical damage to the nerve and artery) visible. The note indicated Resident 4 underwent an open reduction internal fixation (ORIF, type of surgery to stabilize and heal the broken bone) of left distal radius/scaphoid (area of the forearm connected to the wrist) and repair of various hand structures on 6/8/2022. The note indicated the plan to "Elevate LUE Splint to remain in place for 3 months post-operatively (9/8). " b. Adult Patient Discharge Instructions, dated 9/2/2022 - Facility must call for follow-up appointment in 1-2 weeks with Medical Doctor 1 (MD 1), who specializes in hand surgery and plastic surgery.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		

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and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to follow its own policies and procedures on tracheostomy (trach, opening at the front of the neck to allow insertion of a curved tube into the windpipe to assist with breathing) care and the manufacturer ' s guidelines of the disposable inner cannula (DIC, acts as a liner for the trach tube) for one of seven sample residents (Resident 4). This deficient practice had the potential to cause a decline in Resident 4 ' s physical and mental well-being.

Findings:

A review of Resident 4 ' s Admission Record indicated the facility initially admitted the resident on 9/2/2022 with multiple diagnoses including anoxic brain damage (death of brain cells due to lack of oxygen) related to a motorcycle accident, respiratory failure (failure of lungs to deliver enough oxygen into the blood) with tracheostomy, and history of bacterial pneumonia (lung infection).

A review of Resident 4 ' s medical records titled, "History and Physical, " dated 9/2/2022, indicated the resident had fluctuating capacity to understand and make decisions.

A review of Resident 4 ' s Minimum Data Set (MDS, a standardized resident screening and care-planning tool), dated 9/9/2022, indicated Resident 4 responds adequately to simple, direct communication only and lacks the ability to express ideas and wants.

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A Review of Resident 4 ' s medical records titled, "Order Summary Report, " for the period 9/1/2022-9/30/2022, indicated the following physician ' s orders on 9/2/2022:

a. Tracheostomy tube (Shiley, cuffed, size 6) - Change as needed for cuff failure or dislodgement

b. Tracheostomy tube (Shiley, cuffed, size 6) - Change every day shift every one month starting on the 2nd for prevention of tissue granulation and infection.

c. Assess tracheostomy for excessive tracheal and/or oral secretions every 2 hours and as needed for suctioning.

During an interview on 10/13/2022 at 1:54 p.m., Respiratory Therapist 1 (RT 1) stated trach tube changes are done monthly, while the (disposable inner cannula) DIC is changed daily per facility policy. RT 1 stated, on one occasion, Resident 4 ' s DIC was not available at the bedside and the catheter (flexible tubing) could not be inserted to suction Resident 4, so RT 1 cleaned the DIC using the Tracheostomy Clean and Care Tray (kit containing sterile [free from bacteria or other living microorganisms] gloves, cotton-tipped applicators, pipe cleaners, gauze, brush, drape, tray) and reinserted the DIC.

During an observation on 10/14/2022 at 2:24 p.m., RT 1 replaced Resident 6 ' s DIC with a new sterile DIC. RT 1 also demonstrated how she would clean a used DIC per facility practice. RT 1 was observed opening the Tracheostomy Clean and Care Tray and pouring the sterile contents on the sterile drape on the overbed table. RT 1 then

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proceeded soaking the DIC with normal saline (NS, salt solution) in the left compartment of the tray, then cleaning it with the sterile trach brush and pipe cleaners included in the kit. RT 1 then rinsed the used DIC with NS in the right compartment of the tray. RT 1 stated she used the sterile NS in a pink vial and not hydrogen peroxide to clean the DIC.

During a telephone interview on 10/18/2022 at 1:35 p.m., RT Supervisor stated the inability to provide pulmonary hygiene (procedures to clear airway mucus or secretions) alone would not be considered an emergency and would not justify the reuse of a DIC for infection control purposes. RT Supervisor stated on rare occasions when a resident (in general) has a reusable inner cannula, per facility policy, the RT (in general) must soak the used inner cannula in ½ strength hydrogen peroxide (antiseptic solution with one part hydrogen peroxide and one part sterile NS/sterile water) to loosen up dried secretions and kill any bacteria or harmful microorganisms to prevent respiratory infection.

During a telephone interview on 10/27/2022 at 4:26 p.m., the Director of Nursing (DON) stated per facility policy, it was not acceptable to clean and reuse any DIC for infection control purposes. the DON stated if using a reusable inner cannula, the staff must clean it with ½ strength hydrogen peroxide, which was available in the facility, to prevent introduction of infectious diseases.

A review of the manufacturer ' s guidelines of the Shiley trach tube indicated it was classified as a, "disposable medical device. " The guidelines indicated the trach tube and its accessories must be frequently and routinely changed and

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evaluated by the attending physician. The guidelines indicated the DIC was designed for single use and should not be cleaned or reused.

A review of the facility ' s policy and procedures titled, "Disposable Inner Cannula Change, " undated, indicated the resident ' s trach tube DIC must be changed once a day and as needed to maintain a clear and patent airway for the resident and reduce and prevent incidents of infection. The policy indicated after removing the DIC, it must be discarded and replaced with a new sterile DIC.

A review of the facility ' s policy and procedures titled, "Cleaning a Non-Disposable Inner Cannula, " undated, indicated the following procedures:

1. Set up trach care supplies in a clean uncluttered area next to the resident ' s bed.

2. Don a sterile glove on the, "clean, ' hand.

3. Unlock the inner cannula and remove (If resident on mechanical ventilation, trade out the inner cannula to be cleaned with a spare inner cannula and reconnect to the ventilator).

4. Place the inner cannula into the solution of ½ strength hydrogen peroxide and allow to soak for 2-3 minutes.

5. Brush the inside and outside of the inner cannula with a brush or pipe cleaner and ensure all dried secretions are removed.

6. Rinse the inner cannula with sterile NS or sterile water.

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F 695	Continued From page 8 7. Replace the inner cannula into the resident ' s tracheostomy tube and lock (or place in a new plastic bag to trade out inner cannulas in the next cleaning, once the inner cannula is dry).	F 695		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow up General Acute Care Hospital 1 ' s (GACH 1 ' s) discharge order for Occupation Therapy (OT, therapy aimed to improve or maintain the resident ' s ability to perform activities of daily living) for one of seven sample residents (Resident 4). This deficient practice had the potential to cause a further decline in Resident 4 ' s functional mobility.	F 825		

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Findings:

A review of Resident 4 ' s GACH 1 ' s Order Sheet, dated 8/29/202, indicated the physician ' s orders for OT as part of GACH 1 ' s discharge planning.

A review of Resident 4 ' s Admission Record indicated the facility initially admitted the resident on 9/2/2022 with multiple diagnoses including motorcycle accident with laceration of muscle, fascia, and tendon (deep cut on the skin and underlying tissues) at left wrist and multiple fractures (broken bone) to the left and right femur (thigh bone), upper and lower end of fibula (calf bone), lower end of left ulna (medial forearm bone), and lower end of left radius (lateral forearm bone).

A review of Resident 4 ' s medical records titled, "History and Physical, " dated 9/2/2022, indicated the resident had fluctuating capacity to understand and make decisions.

A review of Resident 4 ' s Minimum Data Set (MDS, a standardized resident screening and care-planning tool), dated 9/9/2022, indicated Resident 4 responds adequately to simple, direct communication only and lacks the ability to express ideas and wants. The MDS indicated Resident 4 required extensive assistance with one-person assist with dressing, eating, toilet use, personal hygiene, and bathing. The MDS indicated Resident 4 and the direct care staff believed he is capable of increased independence in at least some activities of daily living (ADLs).

During a telephone interview on 10/18/202 at 4:56

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p.m., Registered Nurse 1 (RN 1) stated she did not recall a physician ' s order for OT upon Resident 4 ' s admission to the facility.

During a concurrent telephone interview and record review, on 10/27/2022 at 4:15 p.m., Occupational Therapist 1 (OT 1) stated it was best to assess, upon resident ' s admission to the facility, the resident ' s (in general) strengths, level of cognition, and functional abilities related to the ADLs to evaluate resident ' s baseline and determine "if there is anything they can do from the start. " OT 1 stated even if the resident could not initiate any activities initially, it was better to start occupational therapy earlier due to possible better prognosis or outcome. OT 1 stated the Director of Rehabilitation Department (DOR) would inform her of OT referrals as ordered by the physician. A review of Resident 4 ' s medical records, there was no documented evidence that Resident 4 received OT at the facility.

During a concurrent telephone interview and record review, on 10/27/2022 at 4:26 p.m., the Director of Nursing (DON) stated the admitting licensed nurse (in general) must enter in the system the physician ' s order for OT per discharge orders from the hospital. A review of Resident 4 ' s GACH 1 records and facility ' s physician orders, the DON stated GACH 1 ' s discharge planning indicated a physician ' s order for OT, but there was no documented evidence of an OT order entered in Resident 4 ' s facility ' s records. The DON stated there was no documented evidence of Resident 4 receiving OT while in the facility.

A review of the facility ' s policy and procedures titled, "Occupational Therapist Job Description, "

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F 825	Continued From page 11 revised on 3/23/2016, indicated the occupational therapist must provide, direct, and supervise all aspects of quality patient care, including, but not limited to, screening, evaluation and treatment, treatment planning, goal setting, family education and documentation, in order to assure the best outcome possible for the resident.	F 825		
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	F 842		

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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.

§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 ensure the medical records for one of

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	055247	A. BUILDING _____ B. WING _____	C 10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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seven sample residents (Resident 4) were complete and accurate. This deficient practice had the potential to cause Resident 4 ' s decline related to inconsistent treatments and care provided to Resident 4.
Findings:

A review of Resident 4 ' s Admission Record indicated the facility initially admitted the resident on 9/2/2022 with multiple diagnoses including anoxic brain damage (death of brain cells due to lack of oxygen) related to a motorcycle accident, respiratory failure with tracheostomy (surgical placement of an opening at the front of the neck into the windpipe to assist with breathing due to the lungs ' inability to deliver enough oxygen into the blood), and presence of gastrostomy (surgical opening into the stomach from abdominal wall to deliver nutrients and medications) and colostomy (surgical opening wherein the large intestine is diverted into an opening on the abdominal wall).

A review of Resident 4 ' s medical records titled, "History and Physical, " dated 9/2/2022, indicated the resident had fluctuating capacity to understand and make decisions.

A review of Resident 4 ' s Minimum Data Set (MDS, a standardized resident screening and care-planning tool), dated 9/9/2022, indicated Resident 4 responds adequately to simple, direct communication only and lacks the ability to express ideas and wants. The MDS indicated Resident 4 required extensive assistance with one-person assist with dressing, eating, toilet use, personal hygiene, and bathing.

A review of Resident 4 ' s, "Change in Condition Evaluation, " dated 9/27/2022, indicated Resident

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4 had an elevated temperature of 102.2 degrees Fahrenheit (F-normal body temperature from 97 deg F to 99 deg F) at 2:29 p.m. and elevated heart rate at 113 (normal heart rate from 60 to 100 beats per minute) at 2:06 p.m. The Evaluation indicated Licensed Vocational Nurse 1 (LVN 1) provided cooling measures and routine pain medication to Resident 4 and notified the primary physician at 2 p.m.

A review of Resident 4 ' s, "Nurses Progress Note, " dated 9/27/2022 and timed at 6:02 p.m., indicated Resident 4 was noted with elevated temperature and heart rate at 2:30 p.m. It indicated cooling measures were applied, "Tylenol given as ordered, " and temperature went down to 98.8 deg F. It indicated at 4:55 p.m., Resident 1 was noted warm with temperature at 102.7 deg F and heart rate at 148. It indicated a physician ' s order was obtained to transfer Resident 4 to the emergency room via 911.

A review of Resident 4 ' s, "Order Summary Report, " for period 9/1/2022 - 9/30/2022, indicated the following physician ' s orders:

1. Tylenol tablet (acetaminophen) - Give 60 milligrams via PEG-tube (feeding tubes inserted through the skin and abdominal wall into the stomach) every 6 hours as needed mild to moderate pain (Start date: 9/25/2022)

2. Acetaminophen tablet 325 milligrams via G-tube every 6 hours as needed for elevated temperature > 100 deg F for 3 days (Start date: 9/12/2022 End date: 9/15/2022)

However, a review of Resident 4 ' s, "Medication

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Administration Record (MAR), " for period 9/1/2022 - 9/30/2022 indicated no Tylenol or acetaminophen was administered to Resident 4 on 9/27/2022 for elevated temperature.

During a telephone interview on 10/18/2022 at 2:11 p.m., Licensed Vocational Nurse 1 (LVN 1) stated she implemented cooling measures for Resident 4 ' s elevated temperature on 9/27/2022, but she could not recall administering any as needed Tylenol or medication for fever. LVN 1 stated she checked Resident 4 ' s temperature, "several times until it went down, " but she did not document these readings on Resident 4 ' s chart.

During a telephone interview on 10/18/2022 at 3:55 p.m., Registered Nurse 2 (RN 2) stated LVN 1 notified her of Resident 4 ' s increased temperature. RN 2 stated ice cooling measures were implemented and Tylenol was administered, but she was unable to recall the time LVN 1 administered it.

During a telephone interview and concurrent record review of Resident 4 ' s physician ' s order and MAR on 10/27/2022 at 4:26 p.m., the Director of Nursing (DON) stated there was no active order for Tylenol (acetaminophen) to be administered for elevated temperature on 9/27/2022. The DON stated there was no documented evidence that Tylenol (acetaminophen) was administered on 9/27/2022 for pain as ordered. The DON stated Resident 4 ' s subsequent temperature assessments were incomplete, because the licensed nurse/s did not document all temperature readings and the time of these assessments on Resident 4 ' s chart.

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A review of Resident 4 ' s General Acute Care Hospital 2 (GACH 2) records titled, "History and Physical Reports, " dated 9/28/2022, indicated Resident 4 was evaluated in the emergency room and found to have sepsis (life-threatening complication of an infection) secondary to abdominal wall abscess (pocket of pus accumulated due to an infection) with cellulitis (bacterial skin infection) and urinary tract infection.

A review of the facility ' s policy and procedures titled, "Charting and Documentation, " dated 5/2010, indicated any changes in the resident ' s medical or mental condition must be documented in the resident ' s medical record. It indicated all observations, medications administered, and services performed, etc. must be documented in the resident ' s clinical records.

A review of the facility ' s policy and procedures titled, "Change in Resident ' s Condition or Status, " dated 1/2012, indicated the nurse supervisor/charge nurse must record in the resident ' s medical record information relative to changes in the resident ' s medical condition or status. The policy indicated assessment related to the change in condition must be documented for 72 hours unless the condition requires continued documentation or the physician orders otherwise.

COUNTRY OAKS
CARE CENTER

F684 Quality of Care

How corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice:

Resident 4 was transferred to the hospital on 9/27/2022.

How the facility will identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken:

On 11/7/2022, charts of other newly admitted residents in last 30 days were reviewed by the IDT to check if discharged/transfer order instructions were followed up.

No other residents were identified affected by the above deficiency.

What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

On 11/8/2022, 11/9/2022, 11/10/2022, 11/11/2022, and 11/12/2022, an in-service education was conducted by the Director of Nursing Services with Licensed Nurses concerning the need to follow up on appointments given by the discharging acute hospitals.

From Monday to Friday, the Medical Records Director (MRD) will audit new admission charts to ensure follow-up appointments were scheduled as ordered. Findings will be reported to the Director of Nursing for appropriate action.

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 is evaluated for its effectiveness. The POC is integrated into the quality assurance system.

The RN Supervisor will complete random weekly chart audits for four (4) consecutive weeks to ensure follow-up appointments are followed as ordered. Findings will be corrected and reported to the Director of Nursing for appropriate action.

Audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.

Corrective action completion date: 11/12/2022

COUNTRY OAKS
CARE CENTER

F695 Respiratory/Tracheostomy Care and Suctioning

How corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice:

Resident 4 was transferred to the hospital on 9/27/2022.

How the facility will identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken:

On 11/5/2022, the RT Lead Supervisor checked other residents' tracheostomy supplies and noted they were available and no other residents were identified affected by the above deficient practice.

What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

All respiratory therapists and licensed nurses were rein-serviced by the lead respiratory supervisor on 11/8/2022 and 11/12/2022 regarding tracheostomy care and manufacturer's guideline for disposable inner cannula, and also addressing the significance of providing clean tracheostomy supplies are available at the bedside of a resident with a tracheostomy. Moreover, all newly hired RT and licensed nurses will be oriented prior to their scheduled shift.

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 is evaluated for its effectiveness. The POC is integrated into the quality assurance system.

Daily, the assigned respiratory therapist and charge nurse will review each resident with a tracheostomy and will ensure that necessary tracheostomy supplies are present at bedside for immediate use if needed.

The lead respiratory therapist and or designee will complete random weekly chart audits for four (4) consecutive weeks to ensure tracheostomy supplies are maintained in a clean and operable condition and are available for immediate use if necessary. Audits will also be made to assure that care plans remain updated to reflect these interventions.

Audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.

Corrective action completion date: 11/12/2022

COUNTRY OAKS
CARE CENTER

F825 Provide/Obtain Specialized Rehab

How corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice:

Resident 4 was transferred to the hospital on 9/27/2022.

How the facility will identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken:

On 11/5/2022, the MRD audited other residents' charts in the last 30 days to check whether an order for rehab that was not followed up.

No other resident was found affected by the above deficiency.

What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

On 11/8/2022, 11/9/2022, 11/10/2022, 11/11/2022, and 11/12/2022, an in-service education was conducted by the Director of Nursing Services with direct care staff addressing the significance of following discharge OT orders from the Acute Hospital.

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 is evaluated for its effectiveness. The POC is integrated into the quality assurance system.

From Monday to Friday, the IDT will review new admissions chart if hospital discharged orders for rehab were followed up as ordered. Findings will be given to the Director of Nursing for appropriate action.

The DON and Rehab designee will complete random weekly chart audits for four (4) consecutive weeks to ensure new admission discharge orders for rehab are followed up. Results of the audits will be submitted to the QA Committee for appropriate action.

Audited records will be reviewed by the Quality Assurance Committee until such time that consistent substantial compliance has been achieved as determined by the committee.

Corrective action completion date: 11/12/2022

COUNTRY OAKS
CARE CENTER

F842 Resident Records - Identifiable Information

How corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice:

Resident 4 was transferred to the hospital on 9/27/2022.

How the facility will identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken:

On 11/5/2022, Medical Records Director audited all current residents with recent change of condition in the last 30 days to ensure that required documentation are accurate and complete.

No other residents were found to be affected by the deficient practice.

What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

On 11/8/2022, 11/9/2022, 11/10/2022, 11/11/2022, and 11/12/2022, an in-service was conducted by the Director of Nursing Services to the Licensed Nurses on documentation, physician orders and signing medication administration and treatment policy and procedure with emphasis on ensuring documentation of resident's condition, assessment and interventions are recorded in the residents' chart. Licensed nurses who were not able to attend and newly hired licensed nurses will be in-serviced prior to starting their scheduled shift.

Medical records will continue to conduct and provide audit(s) and report changes of condition during operations meeting. Any findings will be reported to Director of Nursing for prompt follow up.

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 is evaluated for its effectiveness. The POC is integrated into the quality assurance system.

From Monday to Friday, the MRD will audit residents chart with COCs. Findings will be reported to Director of Nursing for appropriate actions.

The Director of Nursing and or designee will complete random weekly chart audits for four (4) consecutive weeks to ensure compliance. Audits will be submitted to the QAC for appropriate action.

Audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.

Corrective action completion date: 11/12/2022