| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055512 | A. BUILDING _____ B. WING _____ | C 10/04/2022 |

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| WOLF CREEK CARE CENTER | 107 CATHERINE LANE GRASS VALLEY, CA 95945 |

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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during the investigation of a complaint.<br><br>Complaint Number: CA00796979<br><br>Representing the Department:<br><br>Health Facilities Evaluator Nurse: 41715<br><br>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.<br><br>Deficiencies were issued for complaint CA00796979 at F757 and F684. | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to follow its policy and provide showers or baths to two of three sampled residents (Residents 1 and 2). This had the potential to cause skin breakdown and infection, and had the potential to contribute to Resident 1 ' s severe scalp flaking. | F 684 | | |

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

Administrator 10/13/22

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 | | |

Findings:

Resident 1 was an 81-year-old resident with a history of epilepsy (seizures), generalized anxiety disorder, skin cancer and a history of falling.

A review of the facility ' s policy titled, "Showers" (Revised May 2018) indicated that the purpose of the policy was to "ensure cleanliness, provide comfort to the resident and to observe the condition of the resident ' s skin." The policy further indicated "The staff will document the date the shower was performed," and, "Notify the supervisor if the resident refuses the shower/tub bath."

Review of the record, "Skin Monitoring: Comprehensive Shower Review" ("shower sheets"), the facility was able to provide only three recorded showers or attempts to bathe Resident 1 out of a possible 48 opportunities on his scheduled shower days from 2/23/22 to 7/30/22. Only one instance of documenting shower refusals was charted on 5/17/22.

Review of Resident 1's record titled, "Point of Care ADL [activities of daily living] Category Report," dated from March 2022 to August 2022 indicated only six of a possible 48 opportunities where "showers" or tub baths were charted in the patient ' s record (3/15, 3/22, 3/29, 5/20, 5/27 and 6/3/22). On three occasions (3/9, 3/23 and 4/27/22) Resident 1 ' s showers were documented as "refused." Review of the "Personal Hygiene" column entries indicated that the resident had been given towels and washcloths but actual tub baths or showers had not occurred during that time, with no comment

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| F 684 | Continued From page 2 | F 684 | | |

about skin checks that were required to be documented by the Certified Nursing Assistants (CNAs) when bathing.

A review of the facility ' s document titled, "Shower schedule" indicated that Resident 1's shower days should occur twice weekly.

Resident 2 was an 81-year-old resident with a history of cerebrovascular disease (stroke-like event) that led to muscle weakness and paraplegia (paralysis).

Review of Resident 2's "Point of Care ADL Category Report" indicated that from March 2022 to August 2022 there were no documented showers or tub baths. "Personal Hygiene" entries indicated that the Resident 2 had been given materials to conduct "personal hygiene," however actual tub baths or showers had not occurred during that time.

A review of the record titled, "Shower Schedule" (undated) indicated that Resident 2 was to be showered every Monday and Thursday.

In an interview and concurrent record review of the shower policy on 9/28/22 at 12:05 PM, the Director of Nursing (DON) acknowledged that the records for Residents 1 and 2 were incomplete and it was not clear how often those residents had received showers or baths, and that her expectation was that showers get done according to schedule. "If a resident refuses, we reapproach them. If a resident consistently refuses showers, the CNA should bring it to the nurse ' s attention or the Interdisciplinary Team (a meeting of all the care providers) to figure out how we can get

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| F 684 | Continued From page 3<br>around it. I would say If we missed two, we should follow up on it." The DON stated that her plan is now to include in the policy that two refusals of showers will result in the nurse being notified." The DON added that skin is a "huge factor in care of the elderly" and that "these residents need to be babied and assessed."<br><br>In an interview on 9/28/22 at 12:45 PM, Social Services Director (SS) A stated, "Yes, we know he [Resident 1] needs a shower. He refuses. Can we force him? No. There are a few that don ' t want to take showers here. [Resident 2] is another. I don ' t believe the CNAs are documenting the alternatives they offer such as sponge baths. CNAs don ' t have the ability to make narrative notes so it would depend on the nurse to make the note."<br><br>In an interview on 9/28/22 at 1:05 PM, CNA A stated, "If a resident refused a bath or shower completely, we chart it as refused in the medical record. Sometimes shower sheets are missing. We ' ve gotten better."<br><br>In an interview on 9/28/22 at 1:20 PM, CNA B stated that residents should be getting showers at least every 3 days. CNA B acknowledged that Resident 1 frequently refused showers and "says no all the time," and that Resident 2 was another resident who often refused showers.<br><br>In an interview on 9/28/22 at 1:14 PM, Resident 1's relative (RR) stated that Resident 1 had severe flaky skin and scalp irritation as a result from lack of showers and that the scalp is not cleaned by sink baths. | F 684 | | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs | F 757 | | |

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| F 757 | Continued From page 4<br>CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that one of three sampled residents (Resident 1) was free from unneccessary drugs when they failed to adequatelyobtain Resident 1's laboratory results as ordered for monitoring the use of Phenytoin (a medication to prevent seizures). This resulted in Resident 1 experiencing toxic levels of the drug and required hospitalization.<br><br>Findings:<br><br>Resident 1 was an 81-year-old resident with a | F 757 | | |

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| F 757 | Continued From page 5 | F 757 | | |

history of epilepsy (seizures), generalized anxiety disorder, skin cancer and a history of falling.

Review of Resident 1 ' s physician orders, dated 12/9/2020, indicated that he was to receive laboratory blood level tests for phenytoin, "Once a day on the 10th of the Month," from 11/16/21 to 7/10/22. The record was signed by the facility's medical director.

A review of the facility provided record, "Client report, Laboratory," with monthly dates from 3/10/22 to 8/10/22, revealed there was no phenytoin level lab test done in July 2022. The facility's medical records department and Director of Nursing (DON) were unable to provide any laboratory results for that month.

A review of Resident 1 ' s medication administration record, dated 3/22 to 7/22, indicated that phenytoin was administered in July 2022.

Review of the Resident 1's Nursing Notes, dated 7/22/22, indicated that Resident 1 had an unwitnessed fall on that date.

A review of the facility's record titled "IDT (Interdisciplinary Team) Notes" dated 7/26/22, indicated a review of possible causes for the fall. The record further indicated, under "Diagnostic Tests/Lab," that Resident 1's "dilantin levels checked as ordered. Labs as needed," and, "Dilantin recently increased by neurologist and dilantin levels were noted to be very elevated in acute [hospital]." The facility was unable to show evidence that the lab testing for phenytoin was done in the month of July 2022.

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| F 757 | Continued From page 6 | F 757 | | |

A review of Resident 1 ' s nursing progress notes dated 7/23/22 at 6:47 PM, indicated that Resident 1 was given his nighttime medications at 5:05 PM, and that around 6:00 PM, his "speech appeared to be mumbled, left arm was weaker than the right." The resident was sent to a nearby hospital for an evaluation and treatment.

A review of the record "Discharge Summary" provided by the nearby hospital, dated 8/2/22, indicated that Resident 1 ' s phenytoin level was greater than 40 micrograms per milliliter (normal range is 10-20), "immeasurably high" and that his symptoms were "likely due to phenytoin toxicity."

In an interview on 9/27/22 at 3:30 PM, the facility ' s Medical Records Director (MR) stated that no labs were drawn following his fall, and that no July phenytoin lab levels were available because Resident 1 had a visit with his neurologist who was going to provide laboratory results. The facility failed to produce that a record of any July 2022 laboratory results for phenytoin or provide evidence that they were aware of his phenytoin levels while the drug continued to be administered.

In an interview on 9/28/22 at 11:30 AM, Registered Nurse A (RN) A, who routinely administered Resident 1 ' s phenytoin, stated that she had administered a dose of 250 milligrams (mg) of phenytoin at 6 PM on 7/23/22, prior to Resident 1's hospital transfer and that lab levels were unavailable for July 2022 because the facility was "still waiting to receive them." RN A indicated that no new labs were obtained after Resident 1 fell on 7/22/22. RN A stated that dilantin is not a drug that requires frequent monitoring like, for instance, anticoagulants and

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| F 757 | Continued From page 7<br>stated, "We didn ' t look at his labs with every dose, it wasn ' t necessary at that time."<br><br>In an interview and concurrent record review on 9/28/22 at 12:05 PM, the DON confirmed that the facility had not adequately monitored the phenytoin levels and ensured that Resident 1 had a phenytoin level drawn in July 2022, as his physician had ordered. | F 757 | | |

This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

F 684

1. How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
   a. CNAs were in serviced by DSD on (add date) on the importance of documenting all shower refusals.
   b. A new Shower sheet form will be made that gives the CNA a place where they can document if the shower was refused or given, and alternative offered.
   c. CNA will notify nurse of any showers that are refused
   d. Residents 1 and 2 were both offered showers. Documentation of the shower was provided. Both have since received showers.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.
   a. Upon having the knowledge of the situation DSD and DON reviewed shower sheets to find other missing shower logs.
   b. DSD or Designee will interview a sample of residents to ensure they have had the opportunity to receive a shower.

3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.
   a. DSD/designee will develop a new shower sheet to ensure that residents have the opportunity to either accept or refuse a shower. If a resident is continually refusing showers, we will involve the IDT to hold a care conference with resident and RP to help encourage them to shower or create an alternative bathing plan to meet the resident's needs.

4. 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, the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.
    a. DSD/designee will present results of compliance in follow up with residents and CNA's order regarding showers in our monthly QA meeting
    b. Administrator/designee will monitor compliance x 3 months.

5. Date of Completion: October 14, 2022

This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

F 757

1. How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
    a. Resident 1 was sent out to hospital and was stabilized. Since returning we have maintained doctors' orders for drawing labs.
    b. Resident 1 is back in facility and maintained on Phenytoin and monitored by lab level

2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.
    a. All residents taking Phenytoin have the potential to be affected.
    b. MRD has identified all residents that are taking Phenytoin and levels were within therapeutic range.
    c. Upon having knowledge of the situation DON reviewed our lab process and made sure other labs are being carried out and in-serviced nurses on correct lab draw procedures

3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.
    a. MRD will audit lab orders and ensure that they each have results. She will report to DON for any unusual findings and for interventions.

4. 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, the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.

a. MRD will present results of compliance in QA committee.
b. Administrator/Designee will monitor compliance x 3 months.

5. Date of Completion: October 28, 2022