STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555330	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERSIDE POSTACUTE CARE	**8781 LAKEVIEW AVENUE RIVERSIDE, CA 92509**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to report abnormal severely high blood pressure readings to the physician for one of three sampled residents (Resident A). This failure increased the potential for harm for Resident A, and for Resident A's severely high blood pressure to be unidentified or treated. Findings: On December 30, 2019, at 9:31 a.m., the Department received a complaint with allegations regarding the quality of care at the facility. On January 10, 2020, at 9:18 a.m., an unannounced visit was made to the facility for the investigation of the complaint. On January 10, 2020, at 10:44 a.m., Resident A's record was reviewed and indicated Resident A was admitted to the facility on (NAME)8, 2019, with [DIAGNOSES REDACTED]. The record indicated Resident A was ordered to have [MEDICATION NAME]-[MEDICATION NAME] (a blood pressure medication) once daily to treat hypertension (blood pressure readings 140/90 or above, normal reading 120/80). The record indicated Resident A's blood pressure was checked once daily. Resident A's blood pressure readings for December 2019, taken in the mornings, were reviewed and indicated abnormal severely high readings as follows: -On December 12, 2019, Resident A's blood pressure was 168/118 mmHg (mmHg-a unit of measure) taken when the resident was lying down, -On December 13, 2019, 167/100 mmHg, lying down, -On December 18, 2019, 187/76 mmHg, lying down, -On December 19, 2019, 207/125 mmHg, lying down, -On December 24, 2019, 179/87 mmHg, lying down, and -On December 31, 2019, 153/105 mmHg, lying down. There was no documented indication that Resident A's physician was notified of his severely high blood pressure readings, or that nursing staff asked the physician whether Resident A's blood pressure medications needed to be changed. There was no documented indication Resident A's blood pressure was re-checked the same day after his medication was given to see if the medication was effective, and no documented indication the nursing staff questioned Resident A to see if he had any symptoms such as headache, dizziness, or chest pain related to his severely high blood pressure readings on the above dates. On January 17, 2020, Resident A's record was further reviewed. Resident A's Medication Administration Records (MAR)s for December 2019 were compared to the blood pressure readings noted above and indicated the same readings taken once daily. The MARs indicated Resident A had been taking the same dose of blood pressure medication since admission. There was no documented indication Resident A's blood pressures were assessed more than once a day as listed above. Resident A's care plan, dated (NAME)10, 2019, indicated Resident A had hypertension, and nursing interventions included, .Monitor/document/report any s/sx (signs or symptoms) of malignant hypertension (medical emergency blood pressure rises rapidly to 180/120 or above). On January 10, 2020, at 12:30 p.m., Licensed Vocational Nurse (LVN) 1 was interviewed, and stated Resident A's blood pressure did run high. LVN 1 stated the Certified Nursing Assistant (CNA) staff were supposed to notify the LVN if the resident's blood pressure was above 140/90 when checked. LVN 1 stated she would report to the physician if the resident's systolic blood pressure was 170 or above. On January 10, 2020, at 1:47 p.m., CNA 4 was interviewed, and stated the CNA staff did check Resident A's blood pressures. CNA 4 stated if the resident's blood pressure was above 140/80, the CNA was supposed to notify the licensed nurse, and the licensed nurse would re-check the resident's blood pressure. On February 18, 2020, at 4 p.m., Registered Nurse (RN) 1 was interviewed, and stated if the resident's blood pressure was 150/80 or above, the nurse was supposed to ask the resident if they had symptoms of high blood pressure, such as headache or dizziness, and notify the physician of the high reading. RN 1 stated the nurses were supposed to re-check the resident's blood pressure one hour after the blood pressure medication was given to verify whether the resident's blood pressure was improved . RN 1 stated the nurses should document the high blood pressure readings on the change of condition nurse's notes. The facility policy and procedure titled, Change in a Resident's Condition, dated January 2018, was reviewed and indicated, .The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): .significant change in the resident's physical .condition .need to alter the resident's medical treatment . According to Mayo Clinic, retrieved online February 18, 2020, Hypertensive crisis .is a severe increase in blood pressure that can lead to a stroke. Extremely high blood pressure-a top number (systolic pressure) of 180 .mmHg or higher or a bottom number (diastolic pressure) of 120 mmHg or higher can damage blood vessels .As a result, the heart may not be able to pump blood effectively .Causes .include .Stroke .[MEDICAL CONDITION] .If you experience a severe increase in your blood pressure, seek immediate medical attention .
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on interview and record review, the facility failed to ensure Certified Nursing (CNA) staff completed skills competencies upon hire for three of four sampled CNA employees. This failure increased the potential for harm for all residents in the facility to be cared for by staff without validated clinical skills. Findings: On December 30, 2019, at 9:31 a.m., the Department received a complaint with quality of care concerns. On January 10, 2020, at 9:18 a.m., an unannounced visit was made to the facility for the investigation of the complaint. On January 10, 2020, beginning at 1:55 p.m., a sample of employee Human Resources (HR) files were reviewed. The HR files indicated the following: -CNA 1 was hired at the facility on (NAME)19, 2019, and had no documented indication of clinical competencies completed at the time of hire or prior employment references checked, -CNA 2 was hired at the facility (NAME)16, 2019, and had no documented indication of clinical competencies completed at the time of hire, and -CNA 3 was hired at the facility on October 31, 2019, and had no documented indication of clinical competencies completed at hire. On January 10, 2020, at 2:43 p.m., the Director of Staff Development (DSD) was interviewed and stated clinical competencies were usually done within two days of hire and were signed off by the DSD or licensed nursing staff. On February 18, 2020, at 3:20 p.m., a copy of the facility's CNA, Competency Training Checklist form was reviewed. The form indicated CNA skills competencies were assessed by direct observation, demonstration, verbal response or written test. The form included a two page list of multiple skills that were to be checked upon hire and yearly, Critical Elements .Required for all C.N.A.s during On-boarding and Annually . and 3 additional pages of skills to be checked as needed. The form to be signed by the CNA and person who validated the skills indicated the form was supposed to be kept in the employees file and was available upon request. The facility Job Description Certified Nursing Assistant last revised October 19, 2015, was reviewed and indicated, .the Certified Nursing Assistant .Provides patient care in a manner conducive to safety and comfort .Job Skills .Knowledge of procedures and techniques .and providing .patient care services, as permitted by state regulation .

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