STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056185	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF MENIFEE	**27600 ENCANTO DRIVE SUN CITY, CA 92586**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to; 1. Review and update the comprehensive discharge care plan for Resident A; 2. Indicate what the risk for, break in skin integrity, was related to and to implement accurate goals and interventions to meet Resident A's needs; 3. Document in the comprehensive care plan where the break in skin integrity was for Resident A to develop measurable objectives; 4. Indicate for Resident A what his specify pain/discomfort, was related to, to develop valuable goals and interventions to address the pain; and 5. Develop and implement a comprehensive person-centered care plan for four of six sampled residents (Resident A, B, C and D) in a universe of 66 residents to address the residents' pain. These failures had the potential to negatively impact the residents' ability to attain and/or maintain the highest possible level of mental and physical well-being. Findings: On May 28, 2020, at 11:05 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On May 28, 2020, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident A's facility care plans identified a care plan that indicated, Focus: Discharge Plan, with an initiated date of 4/24/2020. The care plan further indicated, Goal: Will develop and follow full discharge plan with comprehensive (sic). The goal ends with the word comprehensive and did not detail or distinguish definitive goals for the resident's safe discharge back into the community. The care plan further indicated, Interventions/Tasks: Unable to determine at this time. The care plan failed to indicate an intervention or task with regards to a safe discharge back into the community for the resident. A review of a care plan for Resident A with the focus, At risk for break in skin integrity, also with an initiated date of 4/24/2020, failed to indicate what the risk of break in skin integrity was related to. It failed to identify what or where on the resident's body the risk was. The care plan indicated, Interventions/Tasks: Clean and dry skin after each incontinent episode, Pressure reducing mattress, Treatment as ordered, Weekly skin checks. Review of a care plan for Resident A with the focus, Has break in skin integrity, with an initiated date of 4/24/2020, failed to identify where the break in skin integrity was. The care plan further indicated, Goal: Minimize risk for symptoms of infection through next review. The care plan indicated, Interventions/Task: Educate resident and/or family regarding skin problem and treatment, Pressure reducing mattress, Treatment as ordered, Weekly skin checks. The care plan failed to indicate what caused the break in skin integrity to accurately implement detailed goals and interventions to meet the resident's need with measurable timelines. Further review of Resident A's facility record found no physician's orders for a pressure reducing mattress or orders for treatment. Review of a care plan for Resident A with the focus, Resident expresses (SPECIFY pain/discomfort) r/t (related to). The focus of the care plan failed to identify what the resident's pain or discomfort was related to. It failed to indicate what the source or cause of the resident's pain and discomfort was. On June 5, 2020, at 11:26 a.m., a phone interview and concurrent record review were conducted with the facility's Director of Nursing (DON). The DON was asked after reviewing Resident A's facility care plans if there should have been documentation that detailed what the skin integrity issues were related to and if the resident's care plan for pain should have documented what the possible source of the pain or discomfort was. The DON stated that those were baseline care plans that had failed to be updated. The DON confirmed that the care plans should have had more detail and interventions. The DON stated that the care plans should have been, reviewed and the interventions either canceled or clarified. On May 28, 2020, a review of Resident B's facility medical record was conducted. Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident B's facility record titled, History and Physical, (H&P) dated May 4, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: 89 Y F (year old female) with chronic back pain admitted with [DIAGNOSES REDACTED]. Further review of Resident B's facility record found no care plan developed nor implemented to address the resident's low back pain or pain from surgery with measurable objectives and timeframes set to meet the resident's needs. On June 5, 2020, a phone interview and concurrent record review were conducted with the facility's DON. The DON was asked after reviewing Resident B's facility care plans if the resident should have had a care plan that addressed the resident's pain given the resident was admitted to the facility after a fall and surgery to fix her femur fracture. The DON was also asked regarding the care plan to address pain for the resident given, Low back pain, was documented as her principal diagnosis. The DON confirmed that it would be expected that the resident would have a care plan for pain. On May 28, 2020, a review of Resident C's facility medical record was conducted. Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident C's facility record titled, History and Physical, (H&P) dated April 29, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: repeated falls, RT (right) hip pain. Further review of Resident C's facility record found no care plan developed nor implemented to address the resident's right hip pain with measurable objectives and timeframes set to meet the resident's needs. On June 5, 2020, a phone interview and concurrent record review were conducted with the facility's DON. The DON was asked after reviewing Resident C's facility care plans if the resident should have had a care plan that addressed the resident's pain given that the resident had Pain in right knee, documented as his third [DIAGNOSES REDACTED]. The DON confirmed that it would be expected that the resident would have a care plan for pain. On May 28, 2020, a review of Resident D's facility medical record was conducted. Resident D was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident D's facility record found no care plan developed nor implemented to address the resident's left knee pain with measurable objectives and timeframes set to meet the resident's needs. On June 5, 2020, a phone interview and concurrent record review were conducted with the facility's DON. The DON was asked after reviewing Resident D's facility care plans if the resident should have had a care plan that addressed the resident's pain. The DON stated, Yes, there should be a care plan for pain. Review of a facility policy titled, Resident Assessment Instrument & Care Plan, issued date, 06/08/2020, indicated, The Care plan includes measure objectives, timeframes to meet the patient's cultural, nursing, mental, and psychosocial needs including services being provided to meet those needs.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure professional standards of quality of care were met for four of six sampled residents (Residents A, B, C and D) in a universe of 66 residents when; 1. The facility failed to ensure comprehensive person-centered care plans were developed and implemented for Resident A with detailed interventions and measurable objectives to address his skin integrity issues; 2. The facility failed to ensure that upon admission to the facility comprehensive person-centered care plans were developed and implemented for four Residents A, B, C and D that addressed the residents' pain; 3. The facility failed to ensure licensed vocational nursing progress notes were documented

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

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) accurately of services provided; and 4. The facility failed to ensure nursing progress notes for Residents A, C and D were not entered with identical documentation for multiple entries. This failure had the potential to place Residents A, C and D at risk for serious medical complications [REDACTED]. Findings: On May 28, 2020, at 11:05 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On May 28, 2020, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident A's facility care plans identified a care plan that indicated, Focus: Discharge Plan, with an initiated date of 4/24/2020. The care plan further indicated, Goal: Will develop and follow full discharge plan with comprehensive (sic). The goal ends with the word comprehensive and did not detail or distinguish definitive goals for the resident's safe discharge back into the community. The care plan further indicated, Interventions/Tasks: Unable to determine at this time. The care plan failed to indicate an intervention or task with regards to a safe discharge back into the community for the resident. A review of a care plan for Resident A with the focus, At risk for break in skin integrity, also with an initiated date of 4/24/2020, failed to indicate what the risk of break in skin integrity was related to. It failed to identify what or where on the resident's body the risk was. The care plan indicated, Interventions/Tasks: Clean and dry skin after each incontinent episode, Pressure reducing mattress, Treatment as ordered, Weekly skin checks. Review of a care plan for Resident A with the focus, Has break in skin integrity, with an initiated date of 4/24/2020, failed to identify where the break in skin integrity was. The care plan further indicated, Goal: Minimize risk for symptoms of infection through next review. The care plan indicated, Interventions/Task: Educate resident and/or family regarding skin problem and treatment, Pressure reducing mattress, Treatment as ordered, Weekly skin checks. The care plan failed to indicate what caused the break in skin integrity to accurately implement detailed goals and interventions to meet the resident's need with measurable timelines. Further review of Resident A's facility record found no physician's orders for a pressure reducing mattress or orders for treatment. Review of a care plan for Resident A with the focus, Resident expresses (SPECIFY pain/discomfort) r/t (related to). The focus of the care plan failed to identify what the resident's pain or discomfort was related to. It failed to indicate what the source or cause of the resident's pain and discomfort was. A review of Resident A's skilled service notes indicated that his Physical Therapy (PT) services were discontinued on May 8, 2020, and that his Occupational Therapy (OT) services were discontinued on May 7, 2020. However, the resident's progress notes dated 5/9/2020, 5/10/2020, 5/11/2020, and 5/12/2020, indicated, continues with skilled pt/ot services tolerated well. Further review of Resident A's facility record identified a, Skilled Note, dated 5/3/2020, authored by a licensed vocational nurse (LVN 1) that had been re-entered with the identical verbiage on 5/4/2020, by LVN 3. Additional review of Resident A's progress notes found multiple, Skilled Notes, with the documentation nearly identical to the previous day's entries. The only changes in the progress notes were the vital signs and the addition of a sentence at the end of the note. On May 28, 2020, a review of Resident B's facility medical record was conducted. Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident B's facility record titled, History and Physical, (H&P) dated May 4, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: 89 Y F (year old female) with chronic back pain admitted with [DIAGNOSES REDACTED]. Further review of Resident B's facility record found no care plan developed nor implemented to address the resident's low back pain or pain from surgery with measurable objectives and timeframes set to meet the resident's needs. A review of Resident B's skilled service notes indicated that her Physical Therapy (PT) services were discontinued on May 15, 2020, and that her Occupational Therapy (OT) services were also discontinued on May 15, 2020. However, the resident's progress notes dated 5/16/2020, 5/17/2020, and 5/18/2020, indicated, Continue with PT and OT as ordered. On May 28, 2020, a review of Resident C's facility medical record was conducted. Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident C's facility record titled, History and Physical, (H&P) dated April 29, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: repeated falls, RT (right) hip pain. Further review of Resident C's facility record found no care plan developed nor implemented to address the resident's right hip pain with measurable objectives and timeframes set to meet the resident's needs. A review of Resident C's skilled service notes indicated that his Physical Therapy (PT) services were discontinued on May 8, 2020, and that his Occupational Therapy (OT) services were discontinued on May 7, 2020. However, the resident's progress notes dated 5/8/2020, 5/9/2020, and 5/10/2020, indicated, Continue with PT/OT for rehab as ordered. Further review of Resident C's facility record identified a progress note dated, 4/29/2020, authored by LVN 2. On 5/2/2020, LVN 2 documented the same entry. The only difference was the vital signs and the last sentence of the entry. On 5/3/2020, 5/4/2020, and 5/5/2020, LVN 2 documented the same skilled note, the only difference in the three separate days entries were the vital signs. On 5/9/2020, LVN 2 entered a skilled note, on 5/10/2020, she entered the same note, the only difference between the notes were the vital signs and in this note the LVN left out, Will continue to monitor. On May 28, 2020, a review of Resident D's facility medical record was conducted. Resident D was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident D's facility record found no care plan developed nor implemented to address the resident left knee pain with measurable objectives and timeframes set to meet the resident's needs. A review of Resident D's skilled service notes indicated that his Physical Therapy (PT) services were discontinued on May 10, 2020, and that his Occupational Therapy (OT) services were discontinued on May 8, 2020. However, the resident's progress notes dated 5/9/2020, and 5/11/2020, indicated, On PT/OT programs. A progress note dated, 5/10/2020, indicated, PT and OT for rehab as ordered. Further review of Resident D's facility record identified a progress note dated, 4/28/2020, authored by LVN 1. On 5/1/2020, LVN 1 documented the same entry, the only difference were the vital signs. On 5/4/2020, LVN 3 documented a progress note. On 5/5/2020, 5/6/2020, 5/8/2020, 5/9/2020 and 5/11/2020, LVN 1 entered the exact same progress note except for the vital signs. On June 5, 2020, at 11:26, a phone interview and concurrent record review were conducted with the facility's Director of Nursing (DON). The DON was asked after reviewing Residents A, B, C and D care plans, if the residents should have had a care plan that addressed their pain. The DON confirmed that the residents should have had a care plan to address their pain. The DON was then asked the facility's expectation for accuracy in documentation. The DON stated that the staff are expected to document the care given to the patient and that the staff should be checking documentation and orders for the residents. The DON further stated that the documentation should be, different on a day to day basis, and is supposed to be accurate. On June 5, 2020, at 1:07 p.m., a concurrent phone interview and record review were conducted with LVN 1. LVN 1 was asked the facility's expectation in documentation. LVN 1 stated, Normally my understanding, was that skilled notes, we will check the patient every single day. When asked about PT and OT services being documented as performed after the services had been discontinued. LVN 1 stated that the documentation, was supposed to be accurate. When asked about multiple entries made with the same documentation, LVN 1 stated that, we should make our own notes, and that they were expected to document, accurately and in detail. On June 15, 2020, at 3:30 p.m., a phone interview was conducted with LVN 2. LVN 2 was asked the facility's expectation in accurate documentation. LVN 2 stated that the facility, wants us to chart everything accurately for that day. LVN 2 continued that they were expected to document any, change of condition, and to document, what we see. When asked why she had documented PT/OT services after the services had been discontinued, the LVN stated that it was, her mistake. The LVN continued that for the most part she tried to check the orders. A review of the Vocational Nursing Practice Act indicated, Scope of Vocational Nursing Practice: The licensed vocational nurse performs services requiring technical and manual skills which include the following: (a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan . It further indicated, .Performance Standards: (a) A licensed vocational nurse shall safeguard patients'/clients' health and safety by actions that include but are not limited to the following: .(2) Documenting patient/client care in accordance with standards of the profession .
F 0675 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor each resident's preferences, choices, values and beliefs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of six sampled residents (Resident A) in a universe of 66 residents received care and services to maintain the highest level of physical and psychosocial well-being when the resident had a complaint of, 10/10, excruciating, pain and there was no documentation that indicated any interventions were implemented nor that the physician was notified to address the resident's pain. This failure had the potential to negatively impact the resident's mental and physical welfare. Findings: On May 28, 2020, at 11:05 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On May 28, 2020, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident A's facility record titled, History and Physical, (H&P) dated April 24, 2020, indicated that, This resident: has

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F 0675 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) the capacity to understand and make decisions. The H&P further indicated, Skin: Psoriasis- some skin ulcer? A review of Resident A's, Minimum Data Set, (MDS- standardized assessment for the management of care) dated April 30, 2020, indicated a BIMS, (brief interview for mental status- screening tool to assess mental capability) score of 15 out of 15 (scores 13-15 indicates cognitively intact). Review of a physical therapy treatment encounter note for Resident A dated, 4/29/2020, indicated, Pain with Movement= 10/10: Frequency = Other (With any pressure or touch, entire back); Location: Entire back: Pain Description/Type: Excruciating. The treatment note was dated 4/29/2020, at 2:17 p.m., and authored by a licensed physical therapy assistant (LPTA 1). Further review of Resident A's facility record found four progress notes dated 4/29/2020. The notes are as follows; -4/29/2020, at 16:41 (4:41 p.m.), IDT Weight Meeting Note. The note made no mention of the resident's complaint of 10/10, Excruciating pain. -4/29/2020, at 14:22 (2:22 p.m.), Skilled Note, the progress note documented, Pnl (pain level) 4/28/2020 11:32 Pain scale: Numerical. The pain documentation entry was dated 4/28/2020, the previous day. The progress noted further indicated, No complaints of pain or discomforted noted. Will continue to monitor . This progress note was authored by a licensed vocation nurse (LVN 1). -4/29/2020, at 13:25 (1:25 p.m.), COMMUNICATION- with Physician. There was no documentation in this progress note that indicated the physician had been informed of the resident's, 10/10, Excruciating pain for orders or interventions to treat it. -4/29/2020, at 04:14 a.m., Health Status Note. The progress note indicated, No C/O (complaint of) pain or discomfort noted. Review of Resident A's, Medication Administration Record [REDACTED]. The record indicated the resident received Tylenol on 4/30/2020, at 01:07 in the morning. A review of Resident A's, Medication Review Report, for the date range of 4/23/2020-5/12/2020, indicated one pain medication ordered. The medication order date was 4/23/2020. The order, [MEDICATION NAME] Tablet (Tylenol) 325 MG (milligram) Give 2 tablet by mouth every 4 hours as needed for mild pain. Review of a care plan for Resident A with the focus, Resident expresses (SPECIFY pain/discomfort) r/t (related to). The focus of the care plan failed to identify what the resident's pain or discomfort was related to. It failed to indicate what the source or cause of the pain and discomfort was or how to address it. On June 4, 2020, at 11:41 a.m., an interview and concurrent record review were conducted with LPTA 1. The LPTA was shown his progress note dated 4/29/2020, for Resident A. The LPTA was asked if he had informed the resident's nurse regarding the resident's complaint of 10/10, Excruciating pain. The LPTA stated that he had informed the nurse about the resident's complaint of pain. The LPTA stated that pressure on the resident's back or any movement would cause the resident pain. The LPTA continued that the resident's back hurt to the touch or when he moved. The LTPA stated again that he had informed the nurse of Resident A's complaint of pain that day. On June 5, 2020, at 11:26 a.m., an interview and concurrent record review were conducted with the facility's Director of Nursing (DON). The DON was asked about the LPTA's documentation of Resident A's, 10/10, Excruciating, pain on 4/29/2020, but that there was no mention of the resident's complaint of pain in any of the other progress notes for that entire day. The DON was asked what the expectation of the facility staff would be if a resident had a severe complaint of 10/10, excruciating pain. The DON stated that if a resident had a complaint of pain in therapy, the therapist would inform the charge nurse and the charge nurse would be expected to reassess the resident. The DON continued that after the resident had been reassessed, the nurse would then contact the physician to inform him of the change in condition. The progress notes for 4/29/2020, were reviewed with the DON, and confirmed no reassessment was documented. The DON stated that she was, not sure about the reassessment, and acknowledged that there was no documentation that indicated the physician had been informed of the resident's change in condition. The DON was asked if a nurse was expected to notify the physician of any change of condition. The DON stated, Yes, it would be an expectation for the nurse to notify the doctor. On June 5, 2020, at 1:07 p.m., a concurrent phone interview and record review were conducted with LVN 1. LVN 1 was asked the facility's expectation of resident's with complaints of pain, LVN 1 stated that they were expected to notify the physician of any change in condition to get an order for [REDACTED]. LVN 2 stated that they were expected to document any change of condition, and to document, what we see. LVN 2 was asked what the process would be if a resident had had a complaint of 10/10, excruciating pain. LVN 2 stated that if a resident had a medication ordered to treat the level of pain, she would administer the ordered medication. The LVN stated that if the pain was, out of the ordinary, she would call the doctor for a change in condition. LVN 2 was asked if Resident A's complaint of 10/10 pain was out of the ordinary. LVN 2 stated, Yes. Review of a facility policy titled, Changes in Resident's Condition or Status, with a review date of 5/5/2020, indicated, This facility will notify the resident, his/her primary caregiver .of changes in the resident's condition or status.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents received treatment and care in accordance to a comprehensive care plan, related to pain management for four of six sampled residents (Resident A, B, C and D) in a universe of 66 residents. This failure occurred when; 1. Resident A's complaint of, 10/10, Excruciating, pain was not reassessed, addressed nor communicated to the physician for orders to treat the resident's pain; and 2. Care plans were not developed nor implemented to address pain for the four residents (Residents A, B, C, and D) with measurable objectives and timeframes set to meet the residents' needs. This failure had the potential to negatively impact the physical and psychosocial well-being of the four residents. Findings: On May 28, 2020, at 11:05 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On May 28, 2020, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident A's facility record titled, History and Physical, (H&P) dated April 24, 2020, indicated that, This resident: has the capacity to understand and make decisions. The H&P further indicated, Skin: Psoriasis- some skin ulcer? A review of Resident A's, Minimum Data Set, (MDS- standardized assessment for the management of care) dated April 30, 2020, indicated a BIMS, (brief interview for mental status- screening tool to assess mental capability) score of 15 out of 15 (scores 13-15 indicates cognitively intact). Review of a physical therapy treatment encounter note for Resident A dated, 4/29/2020, indicated, Pain with Movement= 10/10: Frequency = Other (With any pressure or touch, entire back); Location: Entire back: Pain Description/Type: Excruciating. The treatment note was dated 4/29/2020, at 2:17 p.m., and authored by a licensed physical therapy assistant (LPTA 1). Further review of Resident A's facility record found four progress notes dated 4/29/2020. The notes are as follows; -4/29/2020, at 16:41 (4:41 p.m.), IDT Weight Meeting Note. The note made no mention of the resident's complaint of 10/10, Excruciating pain. -4/29/2020, at 14:22 (2:22 p.m.), Skilled Note, the progress note documented, Pnl (pain level) 4/28/2020 11:32 Pain scale: Numerical. The pain documentation entry was dated 4/28/2020, the previous day. The progress noted further indicated, No complaints of pain or discomforted noted. Will continue to monitor . This progress note was authored by a licensed vocation nurse (LVN 2). -4/29/2020, at 13:25 (1:25 p.m.), COMMUNICATION- with Physician. There was no documentation in this progress note that indicated the physician had been informed of the resident's, 10/10, Excruciating pain for orders or interventions to treat it. -4/29/2020, at 04:14 a.m., Health Status Note. The progress note indicated, No C/O (complaint of) pain or discomfort noted. Review of Resident A's, Medication Administration Record [REDACTED]. The record indicated the resident received Tylenol on 4/30/2020, at 01:07 in the morning. A review of Resident A's, Medication Review Report, for the date range of 4/23/2020-5/12/2020, indicated one pain medication ordered. The medication order date was 4/23/2020. The order, [MEDICATION NAME] Tablet (Tylenol) 325 MG (milligram) Give 2 tablet by mouth every 4 hours as needed for mild pain. Review of a care plan for Resident A with the focus, Resident expresses (SPECIFY pain/discomfort) r/t (related to). The focus of the care plan failed to identify what the resident's pain or discomfort was related to. It failed to indicate what the source or cause of the pain and discomfort was or how to address it. On June 4, 2020, at 11:41 a.m., an interview and concurrent record review were conducted with LPTA 1. The LPTA was shown his progress note dated 4/29/2020, for Resident A. The LPTA was asked if he had informed the resident's nurse regarding the resident's complaint of 10/10, Excruciating pain. The LPTA stated that he had informed the nurse about the resident's complaint of pain. The LPTA stated that pressure on the resident's back or any movement would cause the resident pain. The LPTA continued that the resident's back hurt to the touch or when he moved. The LTPA stated again that he had informed the nurse of Resident A's complaint of pain that day. On June 5, 2020, at 11:26 a.m., an interview and concurrent record review were conducted with the facility's Director of Nursing (DON). The DON was asked about the LPTA's documentation of Resident A's, 10/10, Excruciating, pain on 4/29/2020, but that there was no mention of the resident's complaint of pain in any of the other progress notes for that entire day. The DON was asked what the expectation of the facility staff would be if a resident had a severe complaint of 10/10, excruciating pain. The DON stated that if a resident had a complaint of pain in therapy, the therapist would inform the charge nurse and the charge nurse would be expected to reassess the resident. The DON continued that after the resident had been reassessed, the nurse would then contact the physician to inform him of the change in condition. The progress notes for 4/29/2020, were reviewed with the DON, and

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F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) confirmed no reassessment was documented. The DON stated that she was, not sure about the reassessment, and acknowledged that there was no documentation that indicated the physician had been informed of the resident's change in condition. The DON was asked if a nurse was expected to notify the physician of any change of condition. The DON stated, Yes, it would be an expectation for the nurse to notify the doctor. On June 5, 2020, at 1:07 p.m., a concurrent phone interview and record review were conducted with LVN 1. LVN 1 was asked the facility's expectation of resident's with complaints of pain, LVN 1 stated that they were expected to notify the physician of any change in condition to get an order for [REDACTED]. LVN 2 stated that they were expected to document any change of condition, and to document, what we see. LVN 2 was asked what the process would be if a resident had had a complaint of 10/10, excruciating pain. LVN 2 stated that if a resident had a medication ordered to treat the level of pain, she would administer the order medication. The LVN stated that if the pain was, out of the ordinary, she would call the doctor for a change in condition. LVN 2 was asked if Resident A's complaint of 10/10 pain was out of the ordinary. LVN 2 stated, Yes. On May 28, 2020, a review of Resident B's facility medical record was conducted. Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident B's facility record titled, History and Physical, (H&P) dated May 4, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: 89 Y F (year old female) with chronic back pain admitted with [DIAGNOSES REDACTED]. A review of Resident B's, Minimum Data Set, (MDS- standardized assessment for the management of care) dated May 8, 2020, indicated a BIMS, (brief interview for mental status- screening tool to assess mental capability) score of 10 out of 15 (scores 08-12 indicates moderately impaired). Further review of Resident B's facility record found no care plan developed nor implemented to address the resident's low back pain or pain from surgery with measurable objectives and timeframes set to meet the resident's needs. On May 28, 2020, a review of Resident C's facility medical record was conducted. Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident C's facility record titled, History and Physical, (H&P) dated April 29, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: repeated falls, RT (right) hip pain. A review of Resident C's, Minimum Data Set, (MDS- standardized assessment for the management of care) dated May 1, 2020, indicated a BIMS, (brief interview for mental status- screening tool to assess mental capability) score of 05 out of 15 (scores 13-15 indicates severe impairment). Further review of Resident C's facility record found no care plan developed nor implemented to address the resident's right hip pain with measurable objectives and timeframes set to meet the resident's needs. On May 28, 2020, a review of Resident D's facility medical record was conducted. Resident D was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident D's facility record titled, History and Physical, (H&P) dated April 29, 2020, indicated that, This resident: has the capacity to understand and make decision. Further review of Resident D's facility record found no care plan developed nor implemented to address the resident's left knee pain with measurable objectives and timeframes set to meet the resident's needs. On June 5, 2020, a phone interview and concurrent record review were conducted with the facility's DON. The DON was asked after reviewing Residents A, B, C and D care plans, if the residents should have had a care plan that addressed their pain. The DON confirmed that the residents should have had a care plan to address their pain. Review of the facility policy titled, Pain Assessment and Management, reviewed 5/5/2020, indicated, Purpose: To help residents attain or maintain their highest practicable level of well-being by proactively identifying, care planning, monitoring and managing the resident's pain indicators.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were accurately documented and contained a record of accurate detailed resident's assessments and comprehensive plans of care for four of six sampled residents (Residents A, B, C and D) in a universe of 66 residents when; 1. The facility failed to ensure that upon admission to the facility comprehensive person-centered care plans were developed and implemented for four residents, Residents A, B, C and D that addressed the residents' pain; 2. The facility failed to ensure licensed vocational nursing progress notes were documented accurately of services provided; and 3. The facility failed to ensure nursing progress notes for Residents A, C and D were not entered with identical documentation for multiple entries. Findings: On May 28, 2020, at 11:05 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On May 28, 2020, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident A's facility care plans identified a care plan that indicated, Focus: Discharge Plan, with an initiated date of 4/24/2020. The care plan further indicated, Goal: Will develop and follow full discharge plan with comprehensive (sic). The goal ends with the word comprehensive and did not detail or distinguish definitive goals for the resident's safe discharge back into the community. The care plan further indicated, Interventions/Tasks: Unable to determine at this time. The care plan failed to indicate an intervention or task with regards to a safe discharge back into the community for the resident. A review of a care plan for Resident A with the focus, At risk for break in skin integrity, also with an initiated date of 4/24/2020, failed to indicate what the risk of break in skin integrity was related to. It failed to identify what or where on the resident's body the risk was. The care plan indicated, Interventions/Tasks: Clean and dry skin after each incontinent episode, Pressure reducing mattress, Treatment as ordered, Weekly skin checks. Review of a care plan for Resident A with the focus, Has break in skin integrity, with an initiated date of 4/24/2020, failed to identify where the break in skin integrity was. The care plan further indicated, Goal: Minimize risk for symptoms of infection through next review. The care plan indicated, Interventions/Task: Educate resident and/or family regarding skin problem and treatment, Pressure reducing mattress, Treatment as ordered, Weekly skin checks. The care plan failed to indicate what caused the break in skin integrity to accurately implement detailed goals and interventions to meet the resident's need with measurable timelines. Further review of Resident A's facility record found no physician's orders for a pressure reducing mattress or orders for treatment. Review of a care plan for Resident A with the focus, Resident expresses (SPECIFY pain/discomfort) r/t (related to). The focus of the care plan failed to identify what the resident's pain or discomfort was related to. It failed to indicate what the source or cause of the resident's pain and discomfort was. A review of Resident A's skilled service notes indicated that his Physical Therapy (PT) services were discontinued on May 8, 2020, and that his Occupational Therapy (OT) services were discontinued on May 7, 2020. However, the resident's progress notes dated 5/9/2020, 5/10/2020, 5/11/2020, and 5/12/2020, indicated, continues with skilled pt/ot services tolerated well. Further review of Resident A's facility record identified a, Skilled Note, dated 5/3/2020, authored by a licensed vocational nurse (LVN 1) that had been re-entered with the identical verbiage on 5/4/2020, by LVN 3. Additional review of Resident A's progress notes found multiple, Skilled Notes, with the documentation nearly identical to the previous day's entries. The only changes in the progress notes were the vital signs and the addition of a sentence at the end of the note. On May 28, 2020, a review of Resident B's facility medical record was conducted. Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident B's facility record titled, History and Physical, (H&P) dated May 4, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: 89 Y F (year old female) with chronic back pain admitted with [DIAGNOSES REDACTED]. Further review of Resident B's facility record found no care plan developed nor implemented to address the resident's low back pain or pain from surgery with measurable objectives and timeframes set to meet the resident's needs. A review of Resident B's skilled service notes indicated that her Physical Therapy (PT) services were discontinued on May 15, 2020, and that her Occupational Therapy (OT) services were also discontinued on May 15, 2020. However, the resident's progress notes dated 5/16/2020, 5/17/2020, and 5/18/2020, indicated, Continue with PT and OT as ordered. On May 28, 2020, a review of Resident C's facility medical record was conducted. Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident C's facility record titled, History and Physical, (H&P) dated April 29, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: repeated falls, RT (right) hip pain. Further review of Resident C's facility record found no care plan developed nor implemented to address the resident's right hip pain with measurable objectives and timeframes set to meet the resident's needs. A review of Resident C's skilled service notes indicated that his Physical Therapy (PT) services were discontinued on May 8, 2020, and that his Occupational Therapy (OT) services were discontinued on May 7, 2020. However, the resident's progress notes dated 5/8/2020, 5/9/2020, and 5/10/2020, indicated, Continue with PT/OT for rehab as ordered. Further review of Resident C's facility record identified a progress note dated, 4/29/2020,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056185	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF MENIFEE	**27600 ENCANTO DRIVE SUN CITY, CA 92586**

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) authored by LVN 2. On 5/2/2020, LVN 2 documented the same entry. The only difference was the vital signs and the last sentence of the entry. On 5/3/2020, 5/4/2020, and 5/5/2020, LVN 2 documented the same skilled note, the only difference in the three separate days entries were the vital signs. On 5/9/2020, LVN 2 entered a skilled note, on 5/10/2020, she entered the same note, the only difference between the notes were the vital signs and in this note the LVN left out, Will continue to monitor. On May 28, 2020, a review of Resident D's facility medical record was conducted. Resident D was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident D's facility record found no care plan developed nor implemented to address the resident left knee pain with measurable objectives and timeframes set to meet the resident's needs. A review of Resident D's skilled service notes indicated that his Physical Therapy (PT) services were discontinued on May 10, 2020, and that his Occupational Therapy (OT) services were discontinued on May 8, 2020. However, the resident's progress notes dated 5/9/2020, and 5/11/2020, indicated, On PT/OT programs. A progress note dated, 5/10/2020, indicated, PT and OT for rehab as ordered. Further review of Resident D's facility record identified a progress note dated, 4/28/2020, authored by LVN 1. On 5/1/2020, LVN 1 documented the same entry, the only difference were the vital signs. On 5/4/2020, LVN 3 documented a progress note. On 5/5/2020, 5/6/2020, 5/8/2020, 5/9/2020 and 5/11/2020, LVN 1 entered the exact same progress note except for the vital signs. On June 5, 2020, at 11:26, a phone interview and concurrent record review were conducted with the facility's Director of Nursing (DON). The DON was asked after reviewing Residents A, B, C and D care plans, if the residents should have had a care plan that addressed their pain. The DON confirmed that the residents should have had a care plan to address their pain. The DON was then asked the facility's expectation for accuracy in documentation. The DON stated that the staff are expected to document the care given to the patient and that the staff should be checking documentation and orders for the residents. The DON further stated that the documentation should be, different on a day to day basis, and is supposed to be accurate. On June 5, 2020, at 1:07 p.m., a concurrent phone interview and record review were conducted with LVN 1. LVN 1 was asked the facility's expectation in documentation. LVN 1 stated, Normally my understanding, was that skilled notes, we will check the patient every single day. When asked about PT and OT services being documented as performed after the services had been discontinued. LVN 1 stated that the documentation, was supposed to be accurate. When asked about multiple entries made with the same documentation, LVN 1 stated that, we should make our own notes, and that they were expected to document, accurately and in detail. On June 15, 2020, at 3:30 p.m., a phone interview was conducted with LVN 2. LVN 2 was asked the facility's expectation in accurate documentation. LVN 2 stated that the facility, wants us to chart everything accurately for that day. LVN 2 continued that they were expected to document any, change of condition, and to document, what we see. When asked why she had documented PT/OT services after the services had been discontinued, the LVN stated that it was, her mistake. The LVN continued that for the most part she tried to check the orders. Review of a facility policy titled, Documentation, long-term care, revised, November 15, 2019, indicated, Documentation is the process of preparing a complete record of a resident's care and is a vital tool for communication among health care team members. Accurate, detailed documentation shows the extent and quality of the care that nurses provide, the outcomes of that care, and the treatment and education that the resident still needs. Thorough, accurate documentation decreases the risk of miscommunication and errors and promots continuity of care. The policy further indicated, Document the resident's vital signs, your assessment findings, the resident's care plan, your interventions, and the resident's response to your interventions .