STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555854	A. BUILDING _____ B. WING _____	05/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MESA GLEN CARE CENTER	638 E COLORADO AVENUE GLENDORA, CA 91740

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** - Few	**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 observation, interview and record review the facility failed to develop a resident centered plan of care for one of 3 residents (Residents 2) by failing to: a. Develop a plan of care for Resident 2 who was hospitalized with [MEDICAL CONDITION] (sudden loss of consciousness due to lack of blood flow to the brain) and low heart rate (below 60 beats per minute). b. Develop a plan of care for Resident 2 to consistently assess and monitor for shortness of breath (SOB) and [MEDICAL CONDITION] (lack of [MED]gen in the blood). This deficient practice had the potential for the resident not to receive the necessary care and treatments that could lead to complications of the resident's medical status. Findings: A review of the admission record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) a resident assessment and care screening tool, dated 11/22/19, indicated Resident 2 had unclear speech and severe impairment in cognitive (ability to think and reason) skills and daily decision making. The MDS indicated Resident 2 required extensive assistance with one person on locomotion, transfers and personal hygiene. On 3/11/20 at 10:18 a.m., during an investigation of a Facility Reported Incident (FRI)conducted with the Director of Nursing (DON) stated Resident 2 had two episodes of [MEDICAL CONDITION] that resulted in hospitalization . A concurrent review of the following clinical record indicated the following: a. An SBAR (an acronym for Situation, Background, Assessment, Recommendation; a technique used to facilitate prompt and appropriate communication) indicated on 1/30/20 at 11:24 a.m. indicated Resident 2 was transferred to the hospital due to [MEDICAL CONDITION] and respiratory distress with [MED]gen saturation 74% (normal [MED]gen saturation range 90-100%). b. A review of SBAR, dated 2/17/20, indicated Resident 2 was found unresponsive on the floor in the dining room with [MED]gen saturation on 80% on room air and heart rate of 49 and was transferred to the hospital via 911 ambulance. c. A review of the hospital record, dated 2/17/20, indicated Resident 2 was brought to the emergency room due to syncopal episode and fell which resulted in laceration of right eyebrow, nose, elbow and a fracture (broken bone) of the nasal bones. On 3/13/20 at 11:35 a.m., during a concurrent record review of Resident 2's clinical record and interview with the DON stated, there was no documented evidence a plan of care was developed for Resident 2 to monitor and prevent resident with history of respiratory distress and [MEDICAL CONDITION] and [MEDICAL CONDITION]. The DON stated a plan of care was necessary to communicate with the staff the specific care the resident's needs. According to the facility's undated, policy and procedure, titled Problem Identification List the Interdisciplinary Team will develop and revise comprehensive care plans. Each discipline will provide a written or oral report of the resident's problems, strengths, goals, and approaches as outlined below: a. Problems - Any area of difficulty or concern that prevents the resident from reaching his/her fullest potential. Problems must be stated in behavioral and/or functional terms associated with the [DIAGNOSES REDACTED]. Strengths - Any positive aspects of the resident's overall physical, social, emotional, or spiritual functioning as it relates to the problem. c. Short-Term Goals - The desired outcome for the problem. Short-term goals must be resident oriented, behaviorally stated, measurable, and include a time frame. d. Approach - The specific action(s) or intervention(s) that the staff will take to assist the resident in meeting/achieving the short-term goal(s). e. Time Frame - The time limit assigned to meet each goal.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary care and services for one of 3 sampled residents (Resident 2) with history of [MEDICAL CONDITION] ([MEDICAL CONDITION] or sudden lack of [MED]gen and blood flow to the brain, and [MEDICAL CONDITIONS] (a hardening and narrowing of the arteries in the heart that result in decreased blood flow to the brain and other organs). This deficient practice had the potential for the resident to have a repeated incident of [MEDICAL CONDITION] and low heart rate that could result in a repeated fall incident and a decline in the resident's well-being. Findings: A review of the admission record indicated Resident 2 was admitted to the facility on [DATE] and was readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) a resident assessment and care screening tool, dated 11/22/19, indicated Resident 2 had unclear speech and severe impairment in cognitive (ability to think and reason) skills and daily decision making. The MDS indicated Resident 2 required extensive assistance with one person on locomotion, transfers and personal hygiene. On 3/11/20 at 10:18 a.m. during an investigation of a Facility Reported Incident conducted with the Director of Nursing (DON) stated Resident 2 had an episodes of [MEDICAL CONDITION] that resulted in hospitalization . A concurrent review of the following clinical record indicated the following: a. A review of SBAR, dated 2/17/20, indicated Resident 2 was found unresponsive on the floor in the dining room with [MED]gen saturation on 80% on room air and heart rate of 49 and was transferred to the hospital via 911 ambulance. b. A review of an IDT (Interdisciplinary Team) Conference Record indicated, the family expressed concern that if Resident 2's heart rate is low and feel lightheaded, what measures will the facility take to prevent another fall. c. A review of the hospital record, dated 2/17/20, indicated Resident 2 was brought to the emergency room due to syncopal episode and fell that resulted in laceration of right eyebrow, nose, elbow and a fracture (broken bone) of the nasal bones. On 3/13/20 in a concurrent interview the DON stated, Resident 2 should had been monitored for [MEDICAL CONDITION] and monitor for the heart rate because the resident's heart rate went down to the 30's when she was at the hospital. The DON stated, there was also no record to indicate what exactly caused the low heart rate, she was not referred by the physician to the cardiologist to find out what caused the resident's heart rate to decrease.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to consistently monitor the respiratory status and [MED]gen blood level for one of three residents (Resident 2) with history of [MEDICAL CONDITION] (lack of [MED]gen in the blood), and shortness of breath. This deficient practice had the potential to affect the resident's medical status and well being that could lead to complications whose health status was already compromised. Findings: A review of the admission record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) a resident assessment and care screening tool, dated 11/22/19, indicated Resident 2 had unclear speech and severe impairment in cognitive (ability to think and reason) skills and daily decision making. The MDS indicated Resident 2 required extensive assistance with one person on locomotion, transfers and personal hygiene. On 3/11/20 at 10:18 a.m. during an investigation of a Facility Reported Incident conducted with the Director of Nursing (DON)

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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) stated Resident 2 had two episodes of [MEDICAL CONDITION] that resulted in hospitalization . A concurrent review of the following clinical record indicated the following: a. An SBAR (an acronym for Situation, Background, Assessment, Recommendation; a technique used to facilitate prompt and appropriate communication) indicated on 1/30/20 at 11:24 a.m. indicated Resident 2 was transferred to the hospital due to [MEDICAL CONDITION] and respiratory distress with [MED]gen saturation 74% (normal [MED]gen saturation range 90-100%). b. A review of hospital record indicated Resident 2 with long history of [MEDICAL CONDITION] and was admitted in the emergency room low [MED]genation and was placed on [MEDICAL CONDITION] (Continuous Positive Airway Pressure is a treatment involving a machine that uses mild air pressure to keep your breathing airways open) and improved. The physician ordered to keep Resident 2 on [MED]gen therapy and administer nebulizer (a medication in a form of mist used to open the air pockets in the lungs) as needed. c. A review of a physician order, dated 1/31/20 timed at 5:30 p.m., indicated to readmit Resident 2 to the facility and to administer [MED]gen therapy at 2 liters per minute via nasal cannula (a plastic tube inserted into the nostrils) to maintain [MED]gen saturation above 92% as needed for SOB (shortness of breath). d. A review of SBAR, dated 2/17/20, indicated Resident 2 was found unresponsive on the floor in the dining room with [MED]gen saturation on 80% on room air and heart rate of 49 and was transferred to the hospital via 911 ambulance. e. A review of the hospital record, dated 2/17/20, indicated Resident 2 was brought to the emergency room due to syncopal episode and fell that resulted in laceration of right eyebrow, nose, elbow and a fracture (broken bone) of the nasal bones. f. A review of the physician order, dated 2/20/20, indicated may use [MED]gen via nasal cannula to maintain [MED]gen saturation at 92% as needed for SOB. On 3/11/20 at 11:09 a.m., during an observation conducted with the DON, Resident 1 observed in lying in bed, awake without [MED]gen therapy. In a concurrent interview, Resident 1 nodded, stated Yeah and Yeah and did not reply when asked about the fall. On 3/11/20 at 11:31 a.m., in an interview with the Director of Rehabilitation (DOR) stated Resident 1 was under rehabilitation therapy. The DOR stated, Resident 2 was hospitalized on [DATE] when she observed resident with her purple lips but she had no shortness of breath during therapy. The therapy was stopped and when the nurse checked her [MED]gen level it was low and she was transferred to the hospital. On 3/13/20 at 11:39 a.m., in an interview and concurrent record review the DON stated, she had observed Resident 2 receiving [MED]gen therapy but there was no documented evidence in the clinical record that Resident 2 was consistently monitored for SOB, [MEDICAL CONDITION]. The DON also stated, there was no documented how much [MED]gen was administered and if the [MED]gen saturation was at 92% or greater as ordered by the physician. The DON stated, [MED]gen is medication, the staff should record the [MED]gen amount given and monitor the [MED]gen saturation sat because if not it could lead to [MED]gen toxicity or not enough [MED]gen delivered for the resident. According to the facility's policy and procedure, titled Oxygen Saturation the facility will assess the following before administering [MED]gen and while the resident is receiving [MED]gen therapy by monitoring: a. Signs and symptoms of cyanosis (blue tone to the skin and mucus membrane). b. Signs and symptoms of [MEDICAL CONDITION] (rapid breathing, rapid pulse rate and restlessness and confusion). c. Signs and symptoms of [MED]gen toxicity (tracheal irritation, difficulty breathing, or slow shallow rate of breathing). d. Vital Signs e. Lung Sounds f. Arterial blood gasses and [MED]gen saturation if applicable g. Laboratory results hemoglobin. Hematocrit, complete blood count) if applicable