STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056261	A. BUILDING _____ B. WING _____	**04/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MERRITT MANOR CONVALESCENT HOSPITAL	**604 E. MERRITT AVE. TULARE, CA 93274**

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** Based on observation, interview, and record review, the facility failed to protect one of three sample residents (Resident 1) from abuse when Resident 1 was physically attacked by Resident 2 and Resident 3 during three separate incidents. This failure resulted in Resident 1 sustaining scratches, several skin tears to the right forearm, eyebrows and the top of his head. The resident was subsequently transferred to the hospital after the 10/29/19 incident. Findings: During a review of Resident 1's Progress Notes (PN), dated 8/2/19, the PN indicated at 1:30 PM, . resident (Resident 1) told her that his roommate (Resident 3) hit him . Resident 1 had two scratches to right forearm with discoloration, redness to neck, and scratch to left side of head . Resident (Resident 1) c/o (complained of) left shoulder pain upon assessment. During a review of Resident 1's PN, dated 10/29/19, the PN indicated at 6:25 AM, Resident 2 was on top of Resident 1 straddling him with his right elbow on (Resident 1's) chest and hitting him with his other hand in the face . (Resident 1) was covered in blood and covering his face . I observed skin tears to his right forearm approx (sic) the size of a quarter, a skin tear to his right eyebrow as well as his left eyebrow and a skin tear to the top of his head; res (Resident 1) had excessive amounts of blood all over his right ear, his face and his hair; (Resident 1) whimpered every time I cleaned his skin-tears . he was shaking as I was cleaning him up despite my trying to comfort him . During an interview on 11/5/19, at 8:50 AM with the Administrator, Administrator stated on 10/29/19, the night staff heard noises coming from Resident 1's room and found Resident 2 on top of Resident 1. Administrator stated Resident 1 had received superficial scratches. During a concurrent observation and interview on 11/5/19, at 9:21 AM, with Resident 1, in Resident 1's room, Resident 1 was observed lying down in bed. Resident 1 stated he had been punched and hit but was unable to state who or name the place the incident occurred at. During a concurrent observation and interview on 11/5/19, at 9:55 AM, with Certified Nursing Assistant (CNA) 1 in the dining room activities, Resident 2 was observed sitting down. CNA 1 stated, Resident 2 had some anger problem. Yells at family, yells at staff. Usually has problems with male residents. During an interview on 11/5/19, at 10 AM, with Activity Staff (AS), AS stated on 10/29/19, at 5 AM, she observed Resident 2, walking in the hallway looking lost, and she took him back to his room and laid him down. AS stated, at approximately 6:15 AM, she heard yelling, then grunting. AS stated she looked inside Resident 1's room but the room was too dark, and the privacy curtain was pulled closed so she was unable to see anything. AS stated, I can't say how long (Resident 2) was in the room. During an interview on 11/5/19, at 10:45 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, she had just started her shift on 10/29/19 and witnessed Resident 1 bleeding from his face, he had scratches on his head, and was taken to the hospital. LVN 1 stated Resident 1 had also been previously attacked by another resident (Resident 3). During an interview on 11/5/19, at 11:03 AM, with Assistant Director of Nursing (ADON), ADON stated, Resident 1 had been involved in previous altercations, maybe three or four. ADON stated, on 7/15/19 Resident 3 attacked Resident 1. ADON stated, on 8/2/19 Resident 3 attacked Resident 1. ADON stated, on 10/29/19 Resident 2 attacked Resident 1. During an interview on 11/6/19, at 8:38 AM, with CNA 2, CNA 2 stated, on 10/29/19 she was at the nurses' station when she heard yelling. CNA 2 stated, I saw (Resident 2) on top of resident (Resident 1). CNA 2 stated Resident 1 had sustained a cut, not sure how bad. CNA 2 stated Resident 2 has a habit of lashing out at other residents, that's why he's by himself. CNA 2 stated, there was no hall monitor. During an interview on 11/7/19, at 7:52 AM, with LVN 2, LVN 2 stated, on 10/29/19, at approximately 6:45 AM, she was at the nurses' station when she heard a hooting sound. LVN 2 stated she walked into Resident 1's room, and saw CNA 2 holding Resident 2 back from attacking Resident 1. LVN 2 stated, Resident 1 sustained a skin tear, busted lip, and skin tear to top of head. LVN 2 stated, Resident 2 was territorial, that's why he can't be roomed with any other Residents. During an interview with LVN 3, on 11/13/19, at 7:16 AM, she stated she was sitting at the nurses' station on 10/29/19 when she heard a hooting, cheering noise. LVN 3 stated she walked into Resident 1's room, and saw Resident 2 straddling Resident 1. Resident 2 was hitting Resident 1. During a review of Resident 1's Care Plan (CP), dated 8/2/19, the CP indicated, Resident 1 was involved in a resident to resident altercation; whereby, Resident 1 was the victim. The goals indicated Resident 1 will have no delayed episodes of emotional distress R/T (related to) incident through next review, target date 11/2/19. The interventions indicated, all staff to provide emotional support, notify physician and responsible party. Nursing/social service to monitor for delayed emotional distress, and wound healing. The CP did not indicate intervention(s) implemented to protect Resident 1 from further physical abuse. During a review of Resident 1's CP, dated 10/29/19, the CP indicated, Resident 1 was at risk for potential or actual abuse r/t his dementia and facility population. Resident was the victim of physical aggression. The goals indicated, Resident 1 will be safe and potential for abuse reduced. The updated interventions indicated, Eval (evaluation) at acute hospital, neuro checks, and provide wound care as ordered. The CP did not indicate intervention(s) implemented to protect Resident 1 from further physical abuse. During a review of the policy and procedure titled Abuse Prevention Program dated 2006, indicated Our facility is committed to protecting our residents from abuse by anyone including, but not limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. The implementation of changes to prevent future occurrences of abuse.
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer anti-anxiety medication ([MEDICATION NAME]) to one of two sampled residents (Resident 2) for six days. This omission may have contributed to Resident 2 showing signs of drug withdrawal (physical or psychological symptoms experienced when a drug is abruptly stopped) when Resident 2 became uncontrollably tearful and fearful, yelled at the walls in his room and physically attacked another resident (Resident 1). Findings: During an interview on 11/7/19, at 7:52 AM, with Licensed Vocational Nurse (LVN) 2, she stated Resident 2 had an order for [REDACTED]. LVN 2 stated on 10/28/19 Resident 2 had been acting weird all evening and he had a panic attack earlier in that afternoon. LVN 2 stated Resident 2 may have been acting weird because he hadn't been given his [MEDICATION NAME]. During an interview on 11/7/19, at 2:10 PM, with LVN 4, she reviewed Resident 2's physician's orders [REDACTED]. means it wasn't given. We were waiting for pharmacy to deliver it ([MEDICATION NAME]). They weren't delivering it ([MEDICATION NAME]) because they needed MD signature to ok the medication. During a review of Resident 2's Nurses Notes (NN) dated 10/28/19, at 5:08 PM, the NN indicated Resident (Resident 2) found tearful, crying uncontrollably. Resident fearful of surroundings per nursing. Resident has been pending pharmacy delivery of [MEDICATION NAME] pending MD signature. NN dated 10/29/19, at 6:25 AM, indicated Medication changes made in the past week was clonazapam (sic) delivery was delayed res (Resident 2) has not been receiving dosage in approx 1 week. During an interview on 11/7/19, at 2:30 PM, with Director of Nurses (DON), DON stated he was not aware Resident 2 had not been given his prescribed medication [MEDICATION NAME] for

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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) six days. DON stated, I know they were trying to get a hold of him (MD) but I didn't know it's been that long. Our fax machine was down around that time. During an interview on 11/13/19, at 7:16 AM, with LVN 3, she stated Resident 2's [MEDICATION NAME] had not been delivered from pharmacy. They needed MD signature before they can deliver. LVN 3 stated earlier during her shift on 10/29/19, a CNA had alerted me he (Resident 2) was yelling at the wall. During a review of Resident 2's Comprehensive Care Plan (CCP), revision date on 7/22/19, the CCP indicated, Resident 2 gets nervous and anxious and will pace to the point of exhaustion and taking [MEDICATION NAME] tablet.three times a day for anxiety. The intervention indicated, Please give me my medications that help me with my anxiety. During a review of Resident 2's Nurses Notes (NN) dated 10/28/19, at 5:08 PM, the NN indicated Resident (Resident 2) found tearful, crying uncontrollably. Resident fearful of surroundings per nursing. Resident has been pending pharmacy delivery. NN dated 10/29/19, at 6:25 AM, indicated Medication changes made in the past week was clonazapam (sic) delivery was delayed res (Resident 2) has not been receiving dosage in approx (sic)1 week. NN dated 10/29/19, at 7:07 AM, indicated @ 0625 (at 6:25 AM) writer and CNA (CNA 2) immediately entered the room and found (Resident 2) straddling (Resident 1) pushing down on his face with his elbow and punching him in the face with his free hand. res (Resident 2) was assessed by writer s/t (skin tear) to back of right wrist, bruising and redness to right ear, and contusion to right lower eyelid noted. res (Resident 2) was very confused and scared. During a review of the facility's policy and procedure (P&P) titled, Medication Administration-General Guidelines dated 2007, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. During a review of Lexicomp drug reference database, last reviewed date 4/4/2018, indicated [MEDICATION NAME] had several side affects including but not limited to feeling confused, hallucinations (seeing or hearing things that are not there), bad dreams, patients who take this drug may be at a greater risk of having thoughts or actions of suicide. Do not stop taking this drug all of a sudden without calling your doctors. You may have a greater risk of side affects. If you need to stop this drug, you will want to slowly stop it as ordered by your doctor.