STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055374	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UPLAND REHABILITATION AND CARE CENTER	**1221 EAST ARROW HWY UPLAND, CA 91786**

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 ensure an individualized comprehensive care plan (to provide person centered specific interventions to meet the resident's needs) was initiated and updated for one of three residents (Resident 1), when Resident 1 had a Gastrostomy Tube ([DEVICE]- a tube inserted through the abdominal wall to deliver nutrition, medication, and water directly into the stomach). This failure had the potential to cause inadequate management and interventions for the care of Resident 1's [DEVICE]. Findings: During a concurrent observation and interview on September 18, 2019, Resident 1 was in the activity room, sitting in his wheel chair, and was very frail in appearance. Resident 1 verbalized that he had a [DEVICE] for long time. A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on (NAME)15, 2018, with the [DIAGNOSES REDACTED]. A review of nursing progress notes dated (NAME)28, 2017, indicated Resident 1's [DEVICE] was placed on that day. Resident 1's clinical record indicated Resident 1 was progressed to an oral mechanical soft diet (made easier to chew) on (NAME)29, 2019, and continued to use the [DEVICE] for routine water flush and medication administration. During a review of Resident 1's Order Summary Report (physician orders) dated (NAME)15, 2018, indicated, the physician ordered for a routine free water flush of 100 milliliters (ml- a unit of measurement) of water via [DEVICE] every six hours. The Physician order [REDACTED]. During a concurrent interview and record review of Resident 1's comprehensive care plans' with the Assistant Director of Nursing (ADON) on September 18, 2019, at 5:15 PM, the ADON stated there was no [DEVICE] care plan found for Resident 1 to include the care of the [DEVICE] according to the physician's orders [REDACTED]. A further review with the ADON of the comprehensive care plans for Resident 1 was conducted. A review of a care plan titled (Resident 1) has potential for nutritional problem r/t dysphagia ., had not been updated to include Resident 1 having a [DEVICE] inserted. The ADON stated the care plan intervention did not reflect Resident 1 having a [DEVICE] or the date when it was placed. A review of the facility's policy and procedure titled Nursing Administration: Care plan and Care plan update revised on 2016, indicated Policy .This facility will assure the completion of the resident assessment process enabling the development of an individualized comprehensive care plan for the resident .; Procedures: .3 .All problems, goals, and interventions will be documented in the Resident's comprehensive care plan .7. IDT (interdisciplinary team) team involvement in adhering to these guidelines will ensure consistency in documentation and care plan update .

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.