STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555229	A. BUILDING _____ B. WING _____	**04/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY CONVALESCENT HOSPITAL	**1205 8TH STREET BAKERSFIELD, CA 93304**

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 0773 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician ordered laboratory (lab) tests were obtained for one of three sampled residents (Resident 1). This failure resulted in Resident 1's hemoglobin (protein contained in red blood cells that is responsible for delivery of oxygen to the tissues) and hematocrit (volume of red blood cells compared to the total blood volume) (H&H) to be left unmonitored. Findings: During a review of Resident 1's Laboratory Results, (LR), dated 10/24/19, the LR indicated, Resident 1's H&H was 8.7 (normal range-12.5-18) and 25.9 (normal range-37-52). The Physician Orders, (PO) dated 10/25/19, indicated, complete blood count (CBC, counts the blood cells that make up your blood: red blood cells, white blood cells, and platelets, cells that keep your blood from clotting) was ordered to be drawn on 11/24/19. The LR, dated 1/22/19, indicated, Resident 1's H&H was 6.5 and 20. The PO, dated 1/22/19, indicated, Transfer to (hospital emergency room) for blood transfusion. During a concurrent interview and record review on, 2/21/2020, at 3:11 PM, with Registered Nurse (RN) 1, Resident 1's PO, dated 10/25/19, for CBC to be drawn on 11/24/19 was reviewed. RN1 was unable to provide documentation confirming lab for CBC was drawn on 11/24/19. RN 1 stated lab orders are place into lab book under the date they are to be drawn, the phlebotomist (person trained to collect laboratory samples) initials the log once drawn, if the resident refuses the phlebotomist is to notify the nurse, the nurse and phlebotomist are to countersign the log, the nurse is to document the refusal in the nurses' notes. RN 1 reviewed lab log and confirmed phlebotomist did not draw labs or results were received. RN 1 confirmed there was not any follow up she stated, We trust them (phlebotomists). RN 1 stated, There should be a system. During an interview on, 2/21/2020, at 3:44 PM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated follow up on lab results is hard if it is not endorsed to you. LVN 1 stated the lead nurse is responsible for following up on lab results. During an interview on, 2/21/2020, at 3:48 PM, with LVN 2, LVN 2 stated she ensures her residents labs are drawn and results are received by reviewing the lab book and following up herself. During a concurrent interview and record review on 2/21/2020, at 4 PM, with Director of Nursing (DON), DON stated it is the lead nurse's responsibility to ensure lab requisitions are processed. DON stated it is medical records responsibility to ensure the orders are entered, carried out. DON reviewed the clinical record for Resident 1. DON confirmed the PO dated 10/25/19, for CBC to be drawn 11/24/19, DON was unable to provide lab results for 11/24/19 or documentation indicating Resident 1 refused lab draw. DON stated there is no process to ensure labs are drawn or to track labs results. DON stated, No system is strong here. During an interview on 2/25/2020, at 2:51PM, with RN 1, RN 1 stated if the CBC was drawn on 11/24/19 the results would have been vital in guiding the physicians' care of Resident 1 During an interview on 2/25/2020, at 3:24 PM, with Medical Records Staff (MRS), MRS stated she ensures routine monthly labs are done and results are received. MRS stated the lead nurse is responsible for stat orders and all other orders that are not routine. During a concurrent interview on 2/25/2020, at 3:42 PM, with the Lead Licensed Vocational Nurse (LLVN), LLVN stated all nurses are responsible to ensure labs ordered are placed, labs are drawn, and the results are received. LLVN stated, No one nurse is responsible (for labs). During a review of the facility's policy and procedure (P&P) titled, Request for Diagnostic Services, dated 4/07, the P&P indicated, 3. Orders for diagnostic services will be promptly carried out as instructed by physician's orders [REDACTED].

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.