STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555853	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VETERANS HOME OF CALIFORNIA - BARSTOW	**100 EAST VETERANS PARKWAY BARSTOW, CA 92311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Registered Nurse (RN 2) reported an abuse allegation timely to the abuse coordinator. This failure resulted in a delayed abuse allegation investigation. Findings: A review of Resident 2's clinical record, the facesheet (demographics), indicated, Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an interview with Resident 2 on 3/4/20 at 8:14 AM, Resident 2 stated a Certified Nursing Assistant (CNA 4) refused to change his urinated briefs. Resident 2 stated he reported the incident to the Registered Nurse (RN 2) on 2/21/20. During an interview with the Staff Service Manager (SSM) on 3/4/20 at 12:53 PM, the SSM stated the abuse allegation incident occurred on 2/21/20 around 6:00-7:00 PM. The SSM stated RN 2 reported the abuse allegation the next morning (12 hours after he was made aware of the incident). The SSM stated abuse allegations should be reported immediately to the abuse coordinator. The SSM stated, We dropped the ball on this one. During an interview with the Administrator on 3/4/20 at 1:09 PM, the Administrator stated abuse allegations should be reported immediately to the abuse coordinator. During an interview with the Director of Nurses (DON) on 3/4/20 at 1:20 PM, the DON stated the expectation was to report abuse allegations immediately. The facility's policy and procedure titled, Elder Abuse, Prevention and Reporting, dated, 3/19/19, indicated, .IV. Reporting, The mandated reported is required to complete the Elder Abuse Mandated Reporter form (SOC 341), and report the incident to the Supervisor so that appropriate protection of the Resident can be initiated. All witnessed/alleged violations will be reported immediately to the appropriate authorities. A. Area supervisors and security services will report alleged suspected elder abuse to the Home Administrator or designee.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Certified Nurse Assistant (CNA 4) was removed from all resident care after an abuse allegation was reported. This failure resulted in residents not being protected from harm. Findings: A review of Resident 2's clinical record, the facesheet (demographics), indicated, Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an interview with Resident 2 on 3/4/20 8:14 AM, Resident 2 stated a Certified Nursing Assistant (CNA 4) refused to change his urinated briefs. Resident 2 stated he reported the incident to the Registered Nurse (RN 2) on 2/21/20. During an interview with the Certified Nurse Assistant (CNA 4) on 3/4/20 at 9:08 AM, CNA 4 stated that Resident 2 reported to RN 4 that she refused to change Resident 2's briefs. CNA 4 stated she was removed from Resident 2's care but continued to care for other residents for the remainder of the shift. During an interview with the Administrator on 3/4/20 at 1:09 PM, the Administrator stated CNA 4 should have been removed from all resident care. The facility's policy and procedure titled, Elder Abuse, Prevention and Reporting, dated, 3/19/19, indicated, D. Employee Procedure/Response for Situations, Allegations, And Suspicious of Elder Abuse, indicated, 1. If an employee witnesses, suspects, or is told of an incident of abuse, or identifies an injury of unknown origin that is of suspicious nature, the employee will immediately: d. Protect Residents from harm during an investigation.
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 18 sampled residents (Residents 61 and 54) had their hearing aid's (a small device that fits in the ear for hearing loss) container cases labeled with their name and room number. This failure had the potential for cross contamination should a resident's hearing aid container case be mistaken for someone else's. Additionally, there was increased risk of loosing hearing aid's or having difficulty tracking the location of hearing aid's when not in use. This could result in a decline in residents well-being. Findings: 1. Review of Resident 61's face sheet, indicated, Resident 61 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an observation on 3/2/20 at 10:16 AM, in Resident 61's room, the hearing aid's container case that belonged to Resident 61 was not labeled with resident's identifying information. During an interview on 3/2/20 at 10:17 AM, with Certified Nurse Assistant (CNA 1), CNA 1 confirmed the hearing aid's container case that belonged to Resident 61 was not labeled with resident's name and room number. During an interview on 3/4/20 at 7:26 AM, with Supervisor Registered Nurse (SRN 1), SRN 1 stated that the hearing aid's container case was supposed to be labeled with resident's name. During an interview on 3/4/20 at 10:41 AM, with Certified Nurse Assistant (CNA 3), CNA 3 stated that the hearing aid's container case needed to be labeled with resident's name and room number. During an interview on 3/4/20 at 7:53 AM, Resident 61 stated that he lost his left hearing aid. During an interview on 3/4/20 at 8:11 AM, with Certified Nurse Assistant (CNA 2), CNA 2 stated that its been weeks since Resident 61 left hearing aid had been lost. During an interview on 3/4/20 at 8:13 AM, with SRN 1, SRN 1 stated that Resident 61 received his bilateral hearing aids on 1/10/19 and the left hearing aid was lost on 2/20/20. During a review of Resident 61's clinical record, the Intermittent Resident Inventory List, dated 9/8/18 indicated Resident 61 received his bilateral hearing aid's on 1/10/19. The facility did not provide a policy and procedure regarding labeling the hearing aids container case with residents name and room number per request. 2. Review of Resident 54's clinical record, the face sheet, indicated, Resident 54 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident 54's clinical record, the Intermittent Resident Inventory List, dated 7/9/18, indicated, Resident 54 had a pair of right and left hearing aids. During an observation on 3/2/20 at 12:11 PM, in the small dining room, Resident 54 was eating lunch and was wearing right and left hearing aids. During an interview on 3/2/20 at 12:35 PM, with Resident 54, he stated he wears hearing aids on both his right and left ears because he has hearing loss and cannot hear others without wearing his hearing aids. Resident 54 stated, the staff had not asked him about labeling his hearing aid containers. Resident 54 further stated, he would have liked his hearing aids to be labeled, so that they wouldn't get lost. During an observation on 3/4/20 at 6:51 AM, in Resident 54's room, Resident 54 was awake and resting in bed. An observation was made of his hearing aid container cases not labeled with no name and room number. During an interview on 3/4/20 at 7:01 AM, with the Certified Nursing Assistant (CNA 5), CNA 5 confirmed that Resident 54's right and left hearing aid container cases were not labeled with his name and room number. CNA 5 stated, when hearing aids had no container cases, they were placed in blue containers and had to be labeled with the resident's name and room number. CNA 5 further stated, Resident 54 could not hear without his hearing aids and needed them. During an interview on 3/4/20 at 7:54

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

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F 0676 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) AM, with the Supervisor Registered Nurse (SRN 1), SRN 1 stated the hearing aid containers and cases should be labeled with the resident's name and room number.
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 ensure Vitamin D (supplement used to absorb calcium and promote bone growth) was administered as ordered by the physician for one of 18 sampled residents (Resident 4). This failure had the potential to negatively impact the resident's well-being. Findings: A review of Resident's 4 clinical record, the face sheet (demographics), indicated Resident 4 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. During a medication administration observation on 3/4/20, at 7:09 AM, Licensed Vocational Nurse (LVN 2) was observed administering one tablet of Vitamin D, 5000 (five thousand) International Units (IU). A review of Resident 4's physician order [REDACTED]. During an interview on 3/4/20 at 10:20 AM, LVN 2 confirmed the medication error of giving Resident 4, Vitamin D, 5000 IU on 3/1/20 and 3/4/20. During an interview on 3/4/20 at 10:51 AM, Registered Nurse (RN 1) stated that LVN 2 should have verified the physician's orders [REDACTED]. During an interview on 3/4/20 at 11:02 AM, the Supervisor Registered Nurse (SRN 1) stated that LVN 2 made a medication error. The facility's policy and procedure titled, Administering Medication, dated 4/25/18, indicated, .3. Medications must be administered in accordance with the orders, including any required time frame.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure: 1. Expired Intravenous (IV) medication start kits (sterile needle and catheter to administer medications directly into the bloodstream) were not available for resident use. 2. Opened over-the-counter medications were not labeled with an opened date. These failures had the potential for residents to received expired medications and supplies. Findings: 1. During the medication storage observation on 3/4/20 at 8:45 AM in Unit 700 with the Supervisor Registered Nurse (SRN 1) the following was observed, 12 IV start kits were all dated with an expiration date of 9/30/19. During an interview with SRN 1 on 3/4/20 at 8:45 AM, SRN 1 stated the expired IV start kits should have been discarded because the sterility (state of being free of contaminants) could not be verified beyond the expiration date. 2. During the medication cart observation on 3/4/20 at 9:20 AM in the 800 POD with the Licensed Vocational Nurse (LVN 1), the following was observed, house stock (non-prescription medications used for multiple residents) medications without opened dates written on the containers and the following: A. One bottle of Fish Oil 500 mg (milligrams-unit of measure) 130 softgels (10 softgels remaining). B. One box of [MEDICATION NAME] (cold and cough medicine) 600 mg, 40 tabs (21 tabs remaining). During an interview with LVN 1 on 3/4/20 at 9:20 AM, LVN 1 stated all house stock medications need to be dated when opened. LVN 1 further stated, both the fish oil and [MEDICATION NAME] containers should have been dated, but were not. The facility's policy and procedure titled, Dating Medication When Opened, dated 2/27/20, indicated, Liquid medications and pills in multi-dose containers will be dated upon initial use (e.g., needle-punctured, breaking the seal of the bottle).