STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555307	A. BUILDING _____ B. WING _____	**09/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEARWATER HEALTHCARE CENTER	**1517 EAST KNICKERBOCKER DRIVE STOCKTON, CA 95210**

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a procedure was in accordance with professional standards for one of three sampled residents (Resident 1), when a peripherally inserted central catheter (PICC, a catheter used to administer fluid medications over a long period) was discontinued by a licensed vocational nurse (LVN). This failure increased the potential risk for compromising Resident 1's safety and well-being. Findings: According to the clinical record, Resident 1 was admitted to the facility in early 2020 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 12/9/19, indicated Resident 1 had very mild memory impairment. A review of Resident 1's Progress Notes, dated 12/25/19, indicated, Infiltration to PICC line site on RUA (Right Upper Arm). Ordered by (name), NP (Nurse Practitioner) to remove PICC line. A review of Resident 1's Progress Notes, dated 12/26/19, indicated, Monitoring RUA for redness to PICC line site. PICC line removed d/t infiltration on NOC shift 12/25. No drainage to site at this time. Continues to have redness but progressing. A review of a facility document titled, Employee Disciplinary Action Form, dated 12/26/19, indicated, Removed PICC line of a resident, out of LVN scope of practice .All PICC lines to be removed by RN (Registered Nurse). In an interview on 1/9/20 at 12:59 p.m., Resident 1 stated, I remember, I had a PICC line there before. On 1/9/20 at 1:11 p.m. Resident 1 stated, They removed the PICC line before I went to the hospital. They told me the line was infected. In an interview on 1/9/20 at 1:13 p.m., LN 1 indicated a physician's order would be obtained before removing the PICC line, and stated, I would let my RN supervisor to do it. I don't know if I am able to removed (sic) or D/C a PICC line .If I am not sure, read the policy and procedure. In interview on 1/9/20 at 3:45 p.m., the Director of Nursing (DON) stated, LVNs are not allowed to discontinue PICC line. It's not on their scope of practice. In interview on 2/25/20 at 10:36 a.m., LN 3 stated, An LVN (LN 4) called me and asked me about a PICC line, the dressing was messed up and the resident was itching. In an interview on 2/25/20 at 10:42 a.m., LN 3 indicated he watched LN 4 removed he PICC line, and stated, It was supposed to be the RN. I should have stepped in and be the one to discontinue it .I should have known the policy, I'm sorry. A review of the facility policy and procedure titled, CATHETER REMOVAL, dated 8/16, indicated A nurse with documented education and training in infusion therapy .as designated by the facility, and as allowed by state regulations may remove a PICC or central venous, non-tunneled catheter .It is not within the scope of practice for nurses to remove tunneled catheters or implanted ports. A review of the facility document titled, FACILITY POLICIES AND PROCEDURES, dated 8/16, indicated Policy and procedure manual define types of therapies that may be provided, standards of care, nursing education requirements .it is the nurse's responsibility to obtain approval from the facility administration (usually the Director of Nursing) prior to carrying out the order. A review of the document, titled VOCATIONAL NURSING PRACTICE ACT, California Business and Profession Code, Division 2, Chapter 6.5, Article 2, Scope of Regulation, amended on 7/31/2015, indicated The practice of vocational nursing within the meaning of this chapter is the performance of services requiring those technical, manual skills acquired .practiced under the direction of a licensed physician or registered professional nurse as defined on Section 2725.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program for one of four sampled residents (Resident 1), when a wound dressing was soiled and not labeled, and a Certified Nursing Assistant (CNA) picked up a dirty towel from the floor and placed it on Resident 1's chest. This failure increased the potential risk for infection. Findings: Resident 1 was admitted to the facility in early 2020 with [DIAGNOSES REDACTED]. A review of Resident 1's care plan, dated 12/3/19, indicated, (Resident 1) is on .antibiotic r/t (related to):[MEDICAL CONDITION] PICC (peripherally inserted central catheter) line to right upper arm (RUA). Monitor PICC line site for s/s (signs and symptoms) of infection. A review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 12/9/19, indicated Resident 1 had very mild memory impairment. A review of Resident 1's physician's order, dated 12/18/19, indicated right elbow: cleanse with wound cleanser cover with dry protective dressing as needed for soiling or displacement AND every day shift . A review of Resident 1's Progress Notes, dated 12/26/19, indicated, Monitoring RUA for redness to PICC line site. PICC line removed d/t infiltration on NOC shift 12/25 .Continues to have redness but progressing. In a concurrent observation and interview on 1/9/20 at 12:59 p.m., Resident 1 showed the soiled wound dressing on his right arm, and stated, There should be a mark on there. I'm itchy right now. I need the nurse .I remember, I had a PICC line there before. In an interview on 1/9/20 at 1:08 p.m., LN 1 confirmed the wound dressing was soiled, and stated, The dressing is not labeled, and soiled. In an interview on 1/9/20 at 1:11 p.m., Resident 1 stated, They removed the PICC line before I went to the hospital. They told me the line was infected. In a concurrent observation and interview on 1/9/20 at 1:30 p.m., Certified Nursing Assistant 1 (CNA 1) entered the room, picked up a towel from the floor with her bare hands, and placed it on top of Resident 1's bare chest. When the CNA was asked what she had done, she stated, I'm sorry, I should know better. In an interview on 1/9 20 at 1:38 p.m., Resident 1 stated, I was on antibiotic for UTI for about a week. In an interview on 1/9/20 at 3:31 p.m., when asked what her expectations on LNs on wound dressing, the Assistant Director of Nursing (ADON) stated, Clean their hands, prepare all the supplies, removed the soiled dressing. They put a label, date and time. They should change a soiled dressing and at least as needed. When asked what was her expectations for CNAs on infection control, ADON stated, I would not expect linens to be re-used for the resident when it was already on the floor. A review of the facility policy and procedure titled, Wound Care, dated 10/10, indicated Dress Wound .Mark tape with initials, time, and date and apply to dressing. Be certain all clean items are on clean field . A review of the facility policy and procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 7/14, indicated Resident-care equipment, including reusable items . are cleaned and disinfected or sterilized between resident .

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.