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 _____	**03/23/2020**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** Based on observation, interview, and record review, the facility failed to assess, notify physician and treat one of two sampled residents (Resident 1) when a new bruise was noted on Resident 1's right leg. These failures resulted in delay of care of approximately 36 hours for Resident 1's right tibial (shin, larger bone of the lower leg) fracture. Findings: During a concurrent observation and interview on 2/19/20, at 10:42 AM, with Certified Nursing Assistant (CNA) 1, in Resident 1's room, Resident 1 was lying on top of her bed. Resident 1's right leg was wrapped with a splint (a device used to stabilize injuries by decreasing movement and providing support, preventing further damage), and elevated on a pillow. CNA 1 stated she had given Resident 1 a shower on 1/28/20, at approximately 10 AM, and had noted a new bruise on Resident 1's right leg shin area. CNA 1 stated she had documented the finding on the facility shower sheet and had verbally notified Licensed Vocational Nurse (LVN) 1 of her finding. On 1/29/20, CNA 1 stated she verbally notified LVN 2 of Resident 1's bruising to her right leg shin area. CNA 1 stated It (right leg shin) looked like it was broken, it wasn't protruding or anything but it looked bad. During a review of Resident 1's SBAR (Situation, Background, Assessment and Response (rapid communication tool) Change of Condition (COC) note, dated 1/29/20, at 10:10 PM, the COC indicated, Resident 1 had discoloration to right lower leg and was sent out to acute hospital. During a review of Resident 1's General Note (GN), dated 1/30/20, at 3:28 AM, the GN indicated Resident 1 returned to the facility, Resident has noted splint to right lower extremity r/t (related to) closed right tibial fracture. Hospital Emergency Department note dated 1/30/20 indicated, brought in after care provided is noted her right lower extremity to be bruised and hypermobile E[CONDITION] (emergency medical services) report that they can see what appears to be an obvious deformity in the right lower extremity x-ray confirms a spiral tibial fracture right lower extremity. During an interview on 2/19/20, at 11:46 AM, with LVN 1, LVN 1 stated during her AM shift, on 1/28/20, she was made aware of Resident 1's new bruise to her right lower leg. LVN 1 stated, I didn't get a chance to look at it. I got busy doing something else, so I passed it (information) on to the next shift. During an interview on 2/19/20, at 12:13 PM, with Director of Nursing (DON), DON stated When CNA notify nurses of new skin issues, bruise, skin tear, redness, etc. the nurse will go and assess resident, she will complete a COC. From there she should put a monitoring order or treatment. DON reviewed Resident 1's clinical record and confirmed Resident 1 was not assessed on 1/28/20. DON also confirmed no monitoring or treatment was documented on 1/28/20. During an interview on 2/19/20, at 4:07 PM, with LVN 3, LVN 3 stated during changed of shift room rounds with LVN 4, on 1/29/20, at approximately 10 PM, Her (Resident 1) right foot was off the pillow, we make sure her heel is on the floating device to relieve pressure. When I lifted her foot I saw her bone raised up. During an interview on 2/20/20, at 11:20 AM, with LVN 2, LVN 2 stated she was made aware of Resident 1's new bruise to her right leg on 1/29/20 during AM shift by CNA 1. LVN 2 stated, I went to look at it. I thought AM nurse from the day before had already done a COC and monitoring so I didn't do one. I got busy but I did report it to the next shift (LVN 3). LVN 2 stated a COC should have been done right away. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 11/15, the P&P indicated, 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: b. A discovery of injuries involving the resident; d. A significant change in the resident's physical/emotional/mental condition; 2. A significant change of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. Impacts more than one area of the resident's health status.

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.