STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555435	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RECHE CANYON REGIONAL REHAB CENTER	**1350 RECHE CANYON RD COLTON, CA 92324**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 3 sampled residents (Resident A) received the care in accordance with professional standards of practice when the facility did not have Resident A's dislodged [DEVICE] (gastrointestinal tube, an equipment where nutrition and medication are administered for a resident who is unable to take food orally) re-inserted in a timely manner. This failure resulted in Resident A's delay of treatment for [REDACTED]. Findings: An unannounced visit was conducted on September 10, 2019 at 1:35 PM to investigate a complaint regarding quality of care. During a record review of a Change of Condition (change in health status) for Resident A, dated August 22, 2019 at 2:33 AM, the report indicated Resident A's [DEVICE] was found dislodged and on the side of the bed. The report indicated the medical doctor (MD 1) was notified at 1:00 AM on August 22, 2019 with recommendation to insert a Foley (a tube to keep the site open) on the site and start intravenous fluids. During an interview with the Licensed Vocation Nurse (LVN 1) on September 10, 2019 at 3:00 PM, she Stated she worked on August 22, 2019 and remembered Resident A's [DEVICE] was not yet replaced. She stated All 9 AM meds and 12:00 meds were not given. She stated Resident A did not receive [MEDICATION NAME] and [MEDICATION NAME] (medications for [MEDICAL CONDITION]). She was unable to explain why the Medication Administration Record [REDACTED]. She stated it was a mistake. She meant to document it has not given since she was not able to administer the medications since Resident A's [DEVICE] was out. LVN 1 stated the Gastro-intestinal physician (GI MD) was called but did not show up. A record review of MAR for Resident A, dated August 23, 2019 at 9:00 AM, the report indicated both [MEDICATION NAME] Suspension 125 milligram (mg) / 5 milliliter (ml) and [MEDICATION NAME] Solution 500 mg / 5 ml were administered. The order indicated on the MAR for [MEDICATION NAME] was to give 8 ml via [DEVICE] every 12 hours and for [MEDICATION NAME] to be given 5 ml via [DEVICE] two times a day. Both medications were to be given for [MEDICAL CONDITION]. A record review of Resident A's face sheet (a report that contains personal and medical information of a resident), dated September 10, 2019, indicated Resident A's [DIAGNOSES REDACTED]. During an interview with the Licensed Vocational Nurse 2 (LVN 2) and concurrent record review of Resident A's medical records, on September 10, 2019 at 3:20 PM, LVN 2 stated there were no notes written that the GI MD was notified and there was no evidence that the change of condition for Resident A was followed-up. LVN 2 stated there should have been one. LVN 2 stated the medications for Resident A that were ordered to be given via [DEVICE] would not be administered since the [DEVICE] was out. During an interview with the Director of Nursing (DON) on September 10, 2019 at 3:45 PM, the DON provided the communications log, stating that the information entered in the log drops off after 48 hours and nobody else has access to the older entries except for management. The DON stated the communications log is not part of the residents' medical records. The DON showed the log where it indicated the GI MD was notified on the note posted on August 21, 2019 at 9:28 PM. The same note also indicated an IV D5 NS ([MEDICATION NAME], a combination of normal saline and sugar solution administered intravenously) was started at 75 ml/hr. During a record review of the Communications log, dated August 22, 2019 at 4:50 PM, the log indicated Resident A was on IV fluids and waiting for the GI MD to insert a new [DEVICE]. During a record review of the physician's orders [REDACTED]. NS order. In the same record review, there was also no indication that the medications for Resident A were ordered to be held or stopped. During a record review of the progress notes for Resident A and the communications log for August 2019, there was no indication that the primary physician (MD 1) of Resident A was updated when the [DEVICE] of Resident A was still out for the duration of time and that the medications were not administered. During a record review of the progress notes for Resident A, the note dated August 23, 2019 at 1:46 PM, indicated that Resident had a [MEDICAL CONDITION] at 9:16 AM that lasted for 45 seconds. Resident was transported to (name of general acute care hospital) for tube replacement and follow up on [MEDICAL CONDITION] activity . During an interview with the DON on September 10, 2019 at 4:00 PM, he stated the facility policy when a [DEVICE] is dislodged is to wait for the GI MD come in to replace the [DEVICE]. The DON stated our practice was just changed for that policy, if it were to happen again, send the resident out unless GI MD is in the house to change it immediately. A written policy and procedure was requested. During a record review of the email received from DON, dated September 11, 2019 at 11:02 AM, the email indicated, The facility does not have a specific policy on [DEVICE] dislodgement. It is the facility practice to notify MD and follow any MD orders.

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