STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555872	A. BUILDING _____ B. WING _____	**04/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHAPARRAL HOUSE	**1309 ALLSTON WAY BERKELEY, CA 94702**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility licensed staff did not notify a resident's responsible party (or family) for a change in condition for one of three sampled residents (Resident 1). Resident 1 required the administration of [MED]gen (O2) for low saturations (level of [MED]gen in the blood). This failure resulted in the family not being aware of Resident 1's decline in physical health. Findings: Record review of the document, Admission Record, showed the facility admitted Resident 1 with [DIAGNOSES REDACTED]. Review of the document, Clinical Physician Orders, dated [DATE] showed O2 2 liters via nasal cannula (prongs placed into the nostrils to deliver O2) to keep saturations greater than 92%. Review of the document O2 Sats Summary for Resident 1 showed the following: 12/19/19: 96% Sat on room air at 11:23 p.m. (room air: no [MED]gen being delivered) 12/20/19: 92% Sat on room air at 10:47 a.m. 12/20/19: 92% Sat on room air at 2:03 p.m. 12/20/19: 95% Sat on [MED]gen via nasal cannula at 9:43 p.m. (10 hours after O2 saturation percent dropped). Review of the document, Progress Notes, (or nursing notes) dated 12/21/19 showed Resident 1's saturations continued to drop and she was sent to the hospital's emergency department. There was no documentation in the clinical record which showed staff had notified the family regarding Resident 1's drop in saturation on 12/20/19 and need for supplemental [MED]gen. In an interview at 9:50 a.m. on [DATE], the facility's Director of Nursing (DON) confirmed staff administered [MED]gen for Resident 1 due to dropping saturations and did not notify the family. In an interview at 1:34 p.m. on [DATE], Licensed Vocational Nurse 2 (LVN 2) confirmed he administered the [MED]gen for Resident 1 due to low saturations and had not notified the family. Review of the facility's policy and procedure, Change in a Resident's Condition or Status dated 2007 showed, Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc).
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility licensed staff did not administer [MED]gen as ordered by the physician for one of three sampled residents (Resident 1) in a timely manner. Resident 1 required the administration of [MED]gen (O2) for low saturation (level of [MED]gen in the blood). This failure contributed to Resident 1 experiencing respiratory distress. Findings: Record review of the document Admission Record, showed the facility admitted Resident 1 with [DIAGNOSES REDACTED]. Review of the document,Clinical Physician Orders dated [DATE] showed, O2 2 liters via nasal cannula (prongs placed into the nostrils to deliver [MED]gen) to keep saturations greater than 92%. Review of the document O2 Sats Summary showed the following: 12/20/19: 92% Sat on room air at 10:47 a.m. 12/20/19: 92% Sat on room air at 2:03 p.m. Review of the nurse's documented Progress Notes, dated 12/21/19 showed Resident 1's saturations were not greater than 92% dropped, and she was sent to the hospital's emergency department. There was no documentation in the clinical record which showed staff had administered [MED]gen on 12/20/19 in order to raise the O2 Sat greater than 92% as ordered by the physician. In an interview on [DATE] at 9:50 a.m., the facility's Director of Nursing (DON) confirmed Resident 1's [MED]gen level was low on 12/20/19 and staff did not administer [MED]gen as ordered. In an interview on [DATE] at 10:10 a.m., Licensed Vocational Nurse 1 (LVN 1) confirmed the [MED]gen was not administered for the low O2 Sat. Review of the facility's policy and procedure, Oxygen Administration dated 2004, showed, The purpose of this procedure is to provide guidelines for safe [MED]gen administration. Under the section, Preparation, staff were to, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for [MED]gen administration.

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.