STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056259	A. BUILDING _____ B. WING _____	**06/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHVINE POSTACUTE CARE	**446 ARROWOOD DR SANTA ROSA, CA 95407**

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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform Resident 1's responsible representative in advance of adding a new medication ([MEDICATION NAME]) to Resident 1's medication treatment regimen. (The medication, [MEDICATION NAME], was ordered to dry up the resident's saliva as she was spitting excessively.) This failure denied Resident 1 and her responsible representative the human right to be actively involved in treatment decision-making and care planning, care which was to be based upon an informed discussion with facility nursing and/or medical staff regarding a proposed treatment's rationale, risks, benefits and alternatives. Findings: The medical record of [AGE] year-old Resident 1, admitted to the facility 12/3/16, revealed [DIAGNOSES REDACTED]. Dementia is a chronic disorder caused by brain disease or injury and is marked by memory loss, personality changes, impaired reasoning and cognition. (Due to this dementia, Resident 1 was not capable of making care decisions for herself and thus required assistance from her responsible representative, a close relative.) [MEDICAL CONDITION] is a condition where the bones become brittle and fragile, typically due to hormone changes or low levels of the mineral calcium and the nutrient vitamin D. (The body needs calcium to maintain strong bones and it needs calcium for the muscles to move and for nerves to carry messages between the brain and all body parts. Vitamin D is also needed to maintain strong bones, which is done by helping the body absorb calcium from food and supplements.) A review of Resident 1's Medication Record for October 2019 reflected Resident 1's attending physician ordered a new medication, a [MEDICATION NAME] (which was to be placed on the skin) on 10/9/19 at 9:00 a.m. This medication was ordered to help dry up Resident 1's oral secretions (e.g., saliva), because she was constantly spitting on the floor and on the furniture around her. On 10/11/19 at 5:22 p.m. Licensed Staff B documented in the Progress Notes (Nurses Notes), Got everything for the new order for [MEDICATION NAME]; tried to discuss it with (name) (resident's representative) but there was no answered (sic) asked for her to call me back and she could speak with PM shift nurse as well. There was no documentation to indicate that the resident's representative ever called back and there was no documentation to indicate that further attempts to contact the representative were made prior to initiating the [MEDICATION NAME] order. Resident 1's Medication Administration Record [REDACTED]. However, on 10/12/19 at 8:52 a.m., Licensed Staff B documented on the Nurses Notes, ([MEDICATION NAME]) patches just arrived. First application. Though ordered to be started on 10/9/19 and documented by Staff D as having been administered at 9 a.m. on 10/9/19, the [MEDICATION NAME] was later documented as having been first administered on 10/12/19, three days after receipt of the physician's orders [REDACTED].MD was notified of the above. Gave order to dc (discontinue) [MEDICATION NAME] which was new med started a few days ago (Family Member 1) (resident's representative) contacted and made aware of her (resident's) (sic) changes. Resident 1's representative was thus informed of the order to stop the medication; however, she had not been informed of the order to start it. On 10/16/19 at 11:57 a.m., Licensed Staff B documented on the Nurses Notes, Regarding recent COC (a change of condition) found (Resident 1) was still wearing the [MEDICATION NAME] behind her right ear, I promptly removed it at 0730. Will observe her behavior and condition. On 10/14/19, the physician had ordered that the [MEDICATION NAME] be discontinued/removed from Resident 1's skin. However, this order was not properly followed and the patch remained on Resident 1 for two additional days after receipt of the stop order and before it was removed by Staff B on 10/16/19. This possibly caused Resident 1 to experience two additional days of the medication's negative side effects. Notes from an interdisciplinary team (IDT) care conference held 10/21/19 at 10:15 a.m., reflected that among the topics reviewed with the resident's representative were m. Medication. The notes state, IDT met with (family member1) (resident's representative) and discussed all the above topics, which included item 'A. m. Medication' The 10/21/19 IDT notes reflected, discussed meds, but this occurred only after the [MEDICATION NAME] had already been ordered, administered and discontinued. In a telephone interview on 5/6/20 at 10:15 a.m., Resident 1's representative stated that neither the staff nor the attending physician informed her that this new medication, the [MEDICATION NAME], was being ordered for her (relative). The representative received no information about the risks, benefits or alternatives of this medication and was not given the opportunity to accept or refuse the treatment based on its communicated risks, benefits and alternatives. In an interview on 5/22/20 at 4:20 p.m., Administrative Staff A stated no documentation could be found to reflect nursing or medical staff discussed [MEDICATION NAME] administration with the resident's representative prior to its administration. A facility policy titled, Change in Resident's Condition (dated 1/18) stated, under Process, 6. Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments. Process, 4. stated, Unless otherwise instructed by the resident, a nurse will notify the resident's representative. The facility failed to follow its own policy when it did not notify Resident 1's representative that a new medication was being added to her treatment regimen. A facility policy titled, Residents Rights Guidelines for All Nursing Procedures (dated 1/18) stated under Process, Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including: c. Resident notification of rights, services, and health/medical condition; f. Resident right of refusal (medications and treatments); h. Resident freedom of choice. The facility failed to honor Resident 1 and her representative's right to refuse or choose a medication when it did not inform them about the addition of [MEDICATION NAME] to Resident 1's treatment regimen.
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's nursing staff failed to competently follow physician orders [REDACTED]. Resident 1 already had a low level of vitamin D, which could cause a compromised immune system, impaired wound healing, bone loss and muscle pain. A failure to replace Resident 1's vitamin D in a timely manner could have seriously compromised her health. In addition, because the [MEDICATION NAME] was not stopped/removed as ordered, Resident 1 was placed at risk of experiencing additional days of negative side effects from the drug. These failures demonstrated a lack of competence in order management that potentially placed Resident 1's health and wellness at serious risk. Findings: Resident 1's medical record and laboratory results report showed a lab specimen was drawn on 9/1/19 at 6:15 p.m. to determine the amount of vitamin D in her blood. The results were reported on 9/2/19 at 4:04 p.m. and showed a low vitamin D level of 20 ng/ml (nanogram per milliliter, a unit of measurement). The lab reported the normal value for vitamin D was between 30 and 100 ng/ml, so Resident 1's reading of 20 ng/ml indicated her system had an insufficient amount of vitamin D in it. Resident 1's physician ordered that she begin to receive an oral supplement of vitamin D3 once daily starting

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.

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F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 9/30/19 at 9 a.m. In a review of Resident 1's medical record, it was noted that on 1/16/20 the attending physician had (via fax) ordered to repeat the vitamin D and (vitamin) B12 lab studies. Resident 1's Medication Administration Record [REDACTED]. In an interview on 4/30/20 at 12:25 p.m., Licensed Staff E was asked to locate the vitamin D and vitamin B12 test results from the 1/16/20 order, but no test results could be found. In addition, no evidence could be found to indicate the laboratory was ever informed of the order or drew a blood specimen to complete the order. When Licensed Staff E was asked what procedure staff used to review and confirm new orders were correctly processed, Staff E stated no such procedure existed. In a concurrent interview on 4/30/20 at 12:40 p.m., Administrative Staff F stated she was not aware of any daily procedure to check that orders were processed and were done so correctly. Administrative Staff F added that every shift looked at any outstanding orders and put the resident's medical record binder in a separate space to the left of the binder storage area in the nursing station. The following shift staff then looked at his/her resident's records for new orders. Administrative Staff F added that most physicians did not write orders in the chart, they sent orders to the facility by fax and staff had a separate binder of faxes sent and received. This process reflected how new orders were written, communicated or monitored, but it did not reflect how staff actually verified that steps had been taken to correctly implement those orders. During an interview on 4/30/20 at 1:00 p.m., Administrative Staff A called the laboratory to ask if a requisition for vitamin D and vitamin B12 tests for Resident 1 was received in January of 2020. (Laboratory name) staff stated they received no such requisition. An internet resource, Healthline (https://www.healthline.com/nutrition/vitamin-d-deficiency-symptoms#), indicated a low vitamin D level could cause compromise of the immune system, the body's system that helps it fight infection; impaired wound healing; bone loss and impaired brain function. A review of Resident 1's medical record indicated she was diagnosed with [REDACTED]. Resident 1 experienced moisture-associated skin damage in April of 2020. Resident 1 already had bone loss due to her [DIAGNOSES REDACTED]. order on 1/16/20. This failure placed Resident 1 at risk of receiving an insufficient dose of a vitamin D supplement during that four-month period, which could have contributed to her documented declines in immune system, skin, bone and brain health. In a review of Resident 1's medical record (Order Recap Report), on 5/6/20 at 12:15 p.m. a verbal laboratory test order for vitamin D and calcium levels was received from the attending physician. This (second) order was requested and entered incorrectly as tests for vitamin D and calcium levels, not the vitamin D and vitamin B12 levels that were on the initial (failed) order. A review of Resident 1's medical record and laboratory results report showed that another specimen was drawn on 5/6/20 at 3:53 p.m. to determine vitamin D and calcium levels. The results were reported to staff on 5/7/20 at 1:25 p.m. and showed Resident 1's vitamin D level was now 30 ng/ml (nanogram per milliliter, a unit of measurement) or at the lower end of the normal range of 30-100 ng/ml. The calcium level was also reported to be in the normal range. However, in an interview on 5/8/20 at 12:15 p.m., Administrative Staff A stated the calcium order was requested in error; a vitamin B 12 level should have been requested, not a calcium level. Resident 1's Medication Administration Record [REDACTED]. In an interview on 5/8/20 at 12:15 p.m., Administrative Staff A indicated that another vitamin B12 order had still not been requested or processed to mitigate the incorrectly processed vitamin B12 order from 1/16/20. Given the four-month delay in obtaining this test, Resident 1's physician was unable to determine if the amount of ordered B12 was too much, too little or adequate to ensure Resident 1's optimum nutritional and health status. A Harvard Medical School publication in March 2019 (https://www.health.harvard.edu/a_to_z/vitamin-b12-deficiency-a-to-z) indicated vitamin B12 is needed to produce an adequate amount of red blood cells in the bone marrow, and a deficiency can lead to impaired ability to walk/move, weakness, fatigue, dizziness, weight loss and nausea and - if allowed to remain too long - can cause damage to nerve cells and cause dementia, depression and difficulty walking.) In an interview on 5/8/20 at 2:52 p.m., Administrative Staff A was asked to describe the procedure for ordering a lab test. Administrative Staff A stated, You get an order for [REDACTED]. When the lab comes to the facility, they draw the blood, they generate a result which is faxed to the physician and the result comes up on the (computerized medical record) dashboard. Staff A was asked how someone would know an order was processed correctly and Staff A stated, You won't know unless you go into the lab work results. A review of Resident 1's Medication Record for October 2019 reflected Resident 1's attending physician ordered a new medication, a [MEDICATION NAME] (which was to be placed on the skin) on 10/9/19 at 9:00 a.m. This medication was ordered to help dry up Resident 1's oral secretions (saliva), because she was constantly spitting on the floor and on the furniture around her. On 10/14/19 at 3:40 p.m., Administrative Staff C documented in the Nurses Notes, Resident was observed by RNA staff having trouble walking in hallway, wobbly unsteady gait, balance difficulties .MD was notified of the above. Gave order to dc (discontinue) [MEDICATION NAME] which was new med started a few days ago (Family member) (the resident's representative) contacted and made aware of her (resident's) changes. A Mayo Clinic website, Mayoclinic.org/drugs-supplements, reported the side effects of [MEDICATION NAME] may include blurred vision, drowsiness, dizziness, disorientation or confusion. Resident 1's medical record (the 10/14/19 Nurses Notes) reflected that she experienced many of these symptoms.) On 10/16/19 at 11:57 a.m., Licensed Staff B documented on the Nurses Notes, Regarding recent COC (a change of condition) found (Resident 1) was still wearing the [MEDICATION NAME] behind her right ear, I promptly removed it at 0730. Will observe her behavior and condition. On 10/14/19, the physician had ordered that the [MEDICATION NAME] be discontinued/removed from Resident 1's skin. However, this order was not properly followed and the patch remained on Resident 1 for two additional days after receipt of the stop order and before it was removed by Staff B on 10/16/19. This possibly caused Resident 1 to experience two additional days of the medication's negative side effects.