STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555200	A. BUILDING _____ B. WING _____	**08/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY WEST POST ACUTE	**1224 E STREET WILLIAMS, CA 95987**

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 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to recognize, evaluate, and address the needs of one of seven sampled residents (Resident 4) experiencing impaired hydration (not enough fluids). This failure contributed to Resident 4's admission to the hospital on [DATE] with low blood pressure, kidney failure, and dehydration (not enough fluids). Findings: A review of the facility policy titled, Hydration Program, revised 4/2017, indicated that Certified Nursing Assistants (CNA) and Licensed Nurses (LN) were to record the fluid intake for a resident who had a physician or nursing order. A review of the medical record indicated that Resident 4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 4 was unable to make his own healthcare decisions. A review of a physician order, dated 12/22/19, indicated that Resident 4 was taking [MEDICATION NAME]/[MEDICATION NAME] 12.5 milligrams (mg)/20 mg daily for high blood pressure. Lexicomp (a professional medication information resource) indicated that for residents taking this drug, nursing must monitor blood pressure and fluid status, and record weight and fluid intake and output daily to determine fluid loss. A review of the CNA - ADL (activities of daily living, such as eating, bathing, dressing) Tracking Forms indicated that from 5/21/19 to 6/3/19, Resident 4 refused nine meals, and ate less than half of eight meals. During the previous two weeks from 5/7/19 to 5/20/19, Resident 4 refused only two meals, and ate less than half of only four meals. The documentation did not include the amount of Resident 4's fluid intake. During an interview on 6/20/19 at 10 AM, Licensed Nurse (LN) 2 confirmed that Resident 4 had been taking less the last week and a half of his stay, and that he would refuse help with eating and drinking. During an interview on 6/20/19 at 10:25 AM, CNA 1 stated that Resident 4 used to eat independently, but ate less the last couple of weeks of his stay. CNA 1 stated he would walk away if they tried to help him, and that he refused to eat for his family also. During an interview on 6/20/19 at 10:35 AM, CNA 2 stated that Resident 4 had not been eating well, and he would turn away when they tried to help him. CNA 2 confirmed that he would not eat for his family, either. During a telephone interview through a Language Line interpreter on 7/23/19 at 1:13 PM, Family Member (FM) 1 stated they had never seen the staff take the time to assist Resident 4 to drink. During an interview on 7/24/19 at 11:15 AM, Staff Coordinator (SC) 2 stated that they must use about one or two agency staff daily to supplement their own patient care employees. SC 2 stated that about once or twice a week, they operated without enough patient care staff. During an interview on 7/24/19 at 11:30 AM, the Registered Dietician (RD) stated that she relied on nursing staff to notify her of resident changes in condition, and did not recall being asked to review Resident 4 after 4/5/19. RD stated that she monitored resident fluid intake only if requested by the LN or physician. During a concurrent interview and record review on 7/26/19 at 9:25 AM, CNA 3 stated that the amount of food and fluids consumed by residents was measured and recorded together on the CNA - ADL Tracking Form. CNA 3 stated that they did not measure or monitor fluids separately, and the section for fluids on the form was used to track supplements only. CNA 3 stated that short-staffing often prevented them from helping residents get enough fluids. During a concurrent interview and record review on 7/26/19 at 9:45 AM, LN 4 stated that food and fluids were measured and recorded together on the CNA - ADL Tracking Form, and the fluids section was used only for tracking supplements. LN 4 stated that fluids were not measured separately unless the physician ordered it. LN 4 confirmed that Resident 4 had refused his meals more frequently toward the end of his stay. LN 4 confirmed that if they had done a better job of fluid monitoring, Resident 4's dehydration may have been prevented. During a concurrent interview and record review on 7/26/19 at 10:30 AM, CNA 4 stated that food and fluids were measured and recorded together on the CNA - ADL Tracking Form. CNA 4 confirmed that the fluids section of the Tracking Form was used only for tracking supplements. CNA 4 confirmed that they were always short-staffed, so didn't always have time to help residents get enough fluids. During a concurrent interview and record review on 7/26/19 at 10:40 AM, LN 2 confirmed that they have no separate record for fluid intake. LN 2 stated that normally they do not measure fluids separately. LN 2 confirmed that fluids should be monitored separately from food. A review of a nursing note, dated 6/3/19 at 6:30 PM, indicated that Resident 4 had been taken to the hospital by his family at 6:45 PM. A review of the emergency room notes, dated 6/3/19, indicated that Resident 4 was admitted to the hospital with [REDACTED].

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.