STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555146	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD TERRACE HEALTH CENTER	710 W 13TH AVE ESCONDIDO, CA 92025

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a comprehensive care plan for Resident 22's actual weight loss. This failure had the potential for Resident 22 to not receive person-centered care for their weight loss. Findings: Resident 22 was admitted to the facility on [DATE] as indicated by the Face Sheet. A record review of Resident 22's documented weights was conducted: 12/31/19 120 lbs. 3/2/20 108 lbs. On 3/3/20, a record review of Resident 22's care plans was conducted. A care plan for actual weight loss was not found. On 3/3/20 at 2:41 P.M., an interview with LN 21 was conducted. LN 21 stated, the Registered Dietitian (RD) created Resident 22's nutritional care plan titled, Potential risk for altered nutritional status. During an interview on 3/5/20 at 1:25 P.M. with the Registered Dietitian (RD), the RD stated, Resident 22's nutritional care plan was for potential risk for weight loss. The RD stated, she did not implement a care plan for Resident 22's actual weight loss. A review of the facility's policy and procedure (P&P) titled, Nutrition Alert Committee, dated 1/20, the P&P indicated, During the Nutritional Alert meeting .care plans are updated accordingly.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of two residents (Res38), low air loss mattress (a medical air mattress used to prevent skin breakdown) was properly set up. This failure had the potential to cause Resident 38's pressure ulcer (skin injury which developed because of pressure over a bony area of the body) to worsen. Findings: Resident 38 was admitted to the facility on [DATE] according to the facility's Face Sheet. During an observation on 3/2/20, at 9:38 A.M., in Resident 38's room, Resident 38 was observed in bed, moaning. A low air loss mattress (LAL) was observed on Resident 38's bed. The LAL mattress was set to static 450 lbs. and was locked. A review of Resident 38's Physician order [REDACTED]. A review of Resident 38's skin assessment dated [DATE] indicated, Resident 38 had a stage 1 pressure ulcer (skin injury to the surface layer of skin) on her coccyx and was at risk for pressure ulcers. During an observation on 3/2/20, at 2:53 P.M., in Resident 38's room, Resident 38 was observed in bed. Resident 38's LAL mattress settings was observed and set to static at 450 lbs. ON 3/2/20 2:55 P.M., CNA 24 stated Resident 38 had pressure ulcers on her buttocks and the wound LN had changed Resident 38's pressure ulcer dressings that morning. On 3/4/20 at 9:14 A.M., an interview with CNA 21 was conducted. CNA 21 stated, the LN's were responsible to monitor Resident 38's LAL mattress to ensure the settings were correct. On 3/4/20 at 2:29 P.M., an interview with RNA 21 was conducted. RNA 21 stated, the LAL mattress settings were based on resident's weight and comfort level. RNA 21 stated, he was responsible for checking Resident 38's weight and then he would adjust the settings of Resident 38's LAL mattress based on Resident 38's current weight. RNA 21 stated, he had adjusted Resident 38 LAL mattress settings recently to 150 lbs. RNA 21 stated, 450 lbs was too hard for Resident 38. RNA 21 stated, if the mattress was too hard it defeated the purpose of preventing pressure on the resident's skin. A review of Resident 38's weight log for February 2020 was conducted. On [DATE] Resident 38's weight was documented at 117.8 lbs. On 3/5/20 at 2:22 P.M., an interview with the DON was conducted. The DON stated, LAL mattress settings are based on the resident's weight and comfort. The DON also stated, 450 lbs. was not the correct setting for Residentn 38.
F 0732 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Post nurse staffing information every day.** Based on observation, interview and record review, the facility failed to ensure nurse staffing data was posted in a prominent place accessible to residents and visitors to include: total number of actual hours worked by nursing staff (Registered Nurses, Licensed Vocational Nurses, Certified nurse aides) & resident census. This failure had the potential to result in residents and visitors having to ask the facility for their staffing information. Findings: On 3/5/20 at 3:20 P.M. an observation at the facility's care center nursing station was conducted. The nurse staffing information posted did not include total hours worked by licensed and unlicensed nursing staff for the following categories: Registered Nurses, Licensed Vocational Nurses and Certified Nurse Aides. During an interview with the facility's DSD on 3/5/20 at 3:26 P.M., the DSD stated, the completed nurse staffing information was taken down by the facility's Administrator (Admin) when the facility was remodeled. On 3/5/20 at 3:29 P.M., an interview with the facility's Admin was conducted. The Admin stated, the completed nurse staffing information was in a book at the nurse's station. The Admin stated, going forward it would be posted on the shelf next to our annual survey results for residents and visitors to review.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to remove expired medical supplies and specimen tubes (used to collect samples for medical testing) from one of one medication storage room. In addition, the facility failed to assess for the ability to self-medicate and obtain a physician's orders [REDACTED]. This failure had the potential: 1. to affect the test results for the use of expired medical supplies, and; 2. to place Resident 8 at risk not to take their prescribed medication and gave other residents access to the medications left at the bedside. Findings: 1. On [DATE] at 2:54 P.M., an observation of the medication storage room, and interview was conducted with LN 11. On the counter of the medication room, inside a blue bin, there were five (3 cubic centimeter-cc) syringes with needles had an expiration date of ,[DATE]. On one of the bottom shelf, inside the medication room, a bottle of [MEDICATION NAME] packing strip (used for wound care management) had an expiration date of ,[DATE]. In one of the drawers, inside the medication room, there were 20 pieces of aerobic and anaerobic culture swab tubes (used for specimen collection and transport) with the expiration date of [DATE]. LN 11 stated the medical supplies should have been removed from the medication storage room. LN 11 stated expired medical supplies would have decreased its effectiveness and expired culture swab would no longer provide an accurate result. On [DATE] at 11:28 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated expired medical supplies should have been removed from the medication storage room. Expired culture swab could have a false negative result and would affect the resident's treatment. A review of the facility's undated policy, titled, Storage of Medications, indicated The facility shall store drugs and biologicals in a safe, secure and orderly manner . The facility did not have a specific policy addressing the storage of medical supplies. 2. Resident 8 was admitted to the facility on

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) [DATE], with a [DIAGNOSES REDACTED]. On [DATE] at 8:48 A.M., an observation and interview was conducted of Resident 8 in her room. Resident 8 was sitting in a chair, by herself, and she was holding a medicine cup with numerous medications inside the cup. Resident 8 stated she already took some of her morning medications. On [DATE] at 8:50 A.M., an interview was conducted with LN 12, while in the hallway. LN 12 stated, she had given Resident 8's morning medications that were scheduled for 9 A.M., and thought Resident 8 have taken all her medications. LN 12 went back to Resident 8's room and asked Resident 8 why she had not taken all her medications that she had given her. Resident 8 stated, I waited to take the other half of my medications. On [DATE] at 9 A.M., an observation was conducted with the Director of Nursing (DON) in Resident 8's room. On the floor, was a white round pill, and Resident 8 stated I might have dropped that pill this morning. The DON picked up the pill and stated it was a vitamin. On [DATE], a review of Resident 8's medication record indicated she was scheduled to have received 12 pills at 9 A.M. On [DATE], a review of Resident 8's signed physician orders, dated [DATE], indicated there were no order for Resident 8 to self-administer medications. On [DATE] at 11:24 A.M., an interview was conducted with the DON in her office. The DON stated, the LN should have observed the resident taking all the medications before the LN left the room. The DON further stated, it is our policy for the nurse to observe the resident taking all the pills before leaving the room. Per the facility's policy, undated, titled Self - Administration of Medications, .residents have the right to self - administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so .
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's personal information was protected, when an empty medication bubble pack for one unsampled resident (25) was left on top of a medication cart. This failure had the potential for the resident's information to be viewed by anyone who passed by the cart. Findings: 1. Resident 25 was admitted to the facility on [DATE], per the facility's Profile Face Sheet. On 3/2/20 at 10:09 A.M., an observation was conducted in the hallway of rooms 201 to 214. A medication cart was observed unattended near room [ROOM NUMBER]. On the top of the cart was an empty medication bubble pack that displayed the name of Resident 25, name and strength of the drug, directions for use, expiration date, and the name of the prescriber. On 3/2/20 at 10:17 A.M., a concurrent observation and interview was conducted with the Assistant Director of Nursing (ADON) in front of the medication cart. The ADON picked up the empty medication bubble pack and stated the Licensed Nurse should not have left the medication pack unattended to protect the resident's information. On 3/5/20 at 11:24 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated resident information must be protected and should not be left in an area where information was accessible for public viewing. A review of the facility's policy and procedure, dated 6/28/18, titled Confidentiality of Protected Health Information, indicated . 3 .family and visitors must be restricted from viewing information and may not be left alone in an area where such information is accessible .