STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-PALM DESERT	74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure professional standards of quality of care were met for one of three sampled residents (Residents A) in a universe of 118 residents when; 1. The facility failed to obtain and document a physician's order to send Resident A out of the facility to a dermatology appointment; 2. The facility failed to ensure documentation was entered into the resident's medical record regarding the dermatology appointment and/or the physical and mental state of the resident prior to the appointment and after returning to the facility; and 3. The facility failed to ensure Resident A was sent to a doctor's appointment with a facility staff member. These failures placed the resident at risk for her physical and psychosocial well-being. Findings: On June 16, 2020, at 10:55 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On June 16, 2020, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. movement, muscle tone, or posture), major [MEDICAL CONDITION] (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and [MEDICAL CONDITION] (central nervous system disorder in which brain activity becomes abnormal, causing [MEDICAL CONDITION] or periods of unusual behavior, sensations, and sometimes loss of awareness.) Review of Resident A's, LTC (long term care) Annual History and Physical, dated, 3/2/2020, indicated, .Patient is a poor historian due to [MEDICAL CONDITION] (loss of ability to understand or express speech), dysarthria (motor speech disorder in which the muscles that are used to produce speech are damaged, paralyzed, or weakened) and dementia (group of thinking and social symptoms that interferes with daily functioning) .nursing staff reports patient gets tearful and anxious frequently . A review of Resident A's, Minimum Data Set, (MDS-standardized assessment for the management of care) dated, April 15, 2020, indicated a BIMS, (brief interview for mental status-screening tool to assess mental capability) score of 00 out of 15 (scores 00-07 indicates severe impairment). Review of Resident A's, Social Services, note dated, April 14, 2020, indicated, Patient assessed for admission ARD (Assessment Reference Date) with BIMS of 0/15, indicating severe cognitive impairment. Patient has receptive (disorder in which a person struggles to understand and process the messages and information they receive from others) and expressive (disorder in which a person struggles to get their meaning or messages across to other people) behavior and responds only minimally. Attempt to use communication book and other nonverbal methods were unsuccessful . A review of Resident A's facility record found a copy of a fax titled, Notice of Authorization of Services, dated May 29, 2020. The fax indicated Resident A was authorized to have dermatology consult for, worsening rash to entire body, not improving with treatment . Handwritten on the document was the date, 6/9 @ (at) 10:30 am. Review of a facility progress note for Resident A, dated June 4, 2020, indicated, Pt (patient) A/O (alert and oriented- determination if the person is awake, alert, and oriented to person, place, and time) X1 (oriented to self). Pt non-verbal (does not speak) . A review of Resident A's, Order Summary Report, which included all active, completed, discontinued, pending clinical review, pending confirmation and struck out orders from the date of Resident A's admission found no physician's order to send the resident out of the facility to attend a dermatology appointment. Review of Resident A's facility progress notes and assessments found no documentation entered into the resident's record that indicated that the resident had been scheduled for a dermatology appointment. There was no documentation that the resident had been sent out of the facility to attend a dermatology appointment on June 9, 2020. There was no documentation that the resident had been assessed prior to leaving the facility on June 9, 2020. There was no documentation that the resident had been assessed upon returning from the dermatology appointment on June 9, 2020. On June 16, 2020, at 2:14 p.m., a concurrent interview and record review were conducted with the facility's Administrator (AD) and Director of Nursing (DON). The AD and DON were asked if a physician's order was to have been obtained and expected to be documented in the resident's record for a resident to leave the facility and go to a doctor's appointment. The DON stated that it was, expected to have an order. The AD and DON were then asked the date of Resident A's dermatology appointment. The AD confirmed that the appointment was June 9, 2020. The resident's progress notes were then reviewed in front of the AD and DON. At this time the AD and DON were informed that there was no documentation made for the entire date of June 9, 2020, with regards to the resident having a dermatology appointment. There was no documentation that the resident had been assessed prior to the appointment or upon returning from the appointment. The AD and DON were asked the expectation for documenting if a resident had had an appointment. The DON stated that it would be expected to have documentation about the appointment. The DON further stated there should have been documentation about the resident's state before she had left for the appointment and documentation about her state once she had returned to the facility. The AD and DON were then asked if it was the facility's practice to send a resident to a doctor's appointment alone given that the resident was non-verbal and did not have the capacity to make decisions. The DON stated that the resident was to have had an attendant accompany her to the dermatology appointment but somehow it had not happened. The DON continued that the social worker had informed her that the resident had needed a staff member to go with her to the appointment. The DON stated that she had told the nurse to send someone with the resident but stated that it had not happened. The DON stated that the resident should have had an attendant to accompany her to the appointment. A review of the Vocational Nursing Practice Act indicated, Scope of Vocational Nursing Practice: The licensed vocational nurse performs services requiring technical and manual skills which include the following: (a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan . It further indicated, .Performance Standards: (a) A licensed vocational nurse shall safeguard patients'/clients' health and safety by actions that include but are not limited to the following: .(2) Documenting patient/client care in accordance with standards of the profession .
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that a resident received adequate supervision for one of three sampled residents (Residents A) in a universe of 118. This failure occurred when a non-verbal, cognitively impaired resident was sent out of the facility to a dermatology appointment with no attendant. This failure placed the resident at risk for serious physical and psychosocial harm. Findings: On June 16, 2020, at 10:55 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On June 16, 2020, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. movement, muscle tone, or posture), major [MEDICAL CONDITION] (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and [MEDICAL CONDITION] (central nervous system disorder in which brain activity becomes abnormal, causing [MEDICAL CONDITION] or periods of unusual behavior, sensations,

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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MANORCARE HEALTH SERVICES-PALM DESERT	**74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260**

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and sometimes loss of awareness.) Review of Resident A's, LTC (long term care) Annual History and Physical, dated, 3/2/2020, indicated, .Patient is a poor historian due to [MEDICAL CONDITION] (loss of ability to understand or express speech), dysarthria (motor speech disorder in which the muscles that are used to produce speech are damaged, paralyzed, or weakened) and dementia (group of thinking and social symptoms that interferes with daily functioning) .nursing staff reports patient gets tearful and anxious frequently . A review of Resident A's, Minimum Data Set, (MDS- standardized assessment for the management of care) dated, April 15, 2020, indicated a BIMS, (brief interview for mental status-screening tool to assess mental capability) score of 00 out of 15 (scores 00-07 indicates severe impairment). Review of Resident A's, Social Services, note dated, April 14, 2020, indicated, Patient assessed for admission ARD (Assessment Reference Date) with BIMS of 0/15, indicating severe cognitive impairment. Patient has receptive (disorder in which a person struggles to understand and process the messages and information they receive from others) and expressive (disorder in which a person struggles to get their meaning or messages across to other people) behavior and responds only minimally. Attempt to use communication book and other nonverbal methods were unsuccessful . A review of Resident A's facility record found a copy of a fax titled, Notice of Authorization of Services, dated May 29, 2020. The fax indicated Resident A was authorized to have dermatology consult for, worsening rash to entire body, not improving with treatment . Handwritten on the document was the date, 6/9 @ (at) 10:30 am. Review of a facility progress note for Resident A, dated June 4, 2020, indicated, Pt (patient) A/O (alert and oriented- determination if the person is awake, alert, and oriented to person, place, and time) X1 (oriented to self). Pt non-verbal (does not speak) . On June 16, 2020, at 2:14 p.m., a concurrent interview and record review were conducted with the facility's Administrator (AD) and Director of Nursing (DON). The AD and DON were asked if it was the facility's practice to send a resident to a doctor's appointment alone given that the resident was non-verbal and did not have the capacity to make decisions. The DON stated that the resident was to have had an attendant accompany her to the dermatology appointment but somehow it had not happened. The DON continued that the social worker had informed her that the resident had needed a staff member to go with her to the appointment. The DON stated that she had told the nurse to send someone with the resident but stated that it had not happened. The DON stated that the resident should have had an attendant to accompany her to the appointment.
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 interview and record review the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were accurately documented and contained a record of accurate detailed resident's assessments for one of three sampled residents (Residents A) in a universe of 118 residents when; 1. The facility failed to document a physician's order to send Resident A out of the facility to a dermatology appointment; and 2. The facility failed to ensure documentation was entered into the resident's medical record regarding the dermatology appointment and/or the physical and mental state of the resident prior to the appointment and after returning to the facility. Findings: On June 16, 2020, at 10:55 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On June 16, 2020, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. movement, muscle tone, or posture), major [MEDICAL CONDITION] (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and [MEDICAL CONDITION] (central nervous system disorder in which brain activity becomes abnormal, causing [MEDICAL CONDITION] or periods of unusual behavior, sensations, and sometimes loss of awareness.) A review of Resident A's facility record found a copy of a fax titled, Notice of Authorization of Services, dated May 29, 2020. The fax indicated Resident A was authorized to have dermatology consult for, worsening rash to entire body, not improving with treatment . Handwritten on the document was the date, 6/9 @ (at) 10:30 am. A review of Resident A's, Order Summary Report, which included all active, completed, discontinued, pending clinical review, pending confirmation and struck out orders from the date of Resident A's admission found no physician's order to send the resident out of the facility to attend a dermatology appointment. Review of Resident A's facility progress notes and assessments found no documentation entered into the resident's record that indicated that the resident had been scheduled for a dermatology appointment. There was no documentation that the resident had been sent out of the facility to attend a dermatology appointment on June 9, 2020. There was no documentation that the resident had been assessed prior to leaving the facility on June 9, 2020. There was no documentation that the resident had been assessed upon returning from the dermatology appointment on June 9, 2020. On June 16, 2020, at 2:14 p.m., a concurrent interview and record review were conducted with the facility's Administrator (AD) and Director of Nursing (DON). The AD and DON were asked if a physician's order was expected to be documented in the resident's record for a resident to leave the facility and go to a doctor's appointment. The DON stated that it was, expected to have an order. The AD and DON were then asked the date of Resident A's dermatology appointment. The AD confirmed that the appointment was June 9, 2020. The resident's progress notes were then reviewed in front of the AD and DON. At this time the AD and DON were informed that there was no documentation made for the entire date of June 9, 2020, with regards to the resident having a dermatology appointment. There was no documentation that the resident had been assessed prior to the appointment or upon returning from the appointment. The AD and DON were asked the expectation for documenting if a resident had had an appointment. The DON stated that it would be expected to have documentation about the appointment. The DON further stated there should have been documentation about the resident's state before she had left for the appointment and documentation about her state once she had returned to the facility. Review a facility policy titled, Documentation, updated, 07/2017, indicated, Licensed Nurse Documentation, Licensed nurse documentation in the clinical record is expected to follow established practices .Progress Note: Patient evaluation, communications .completion of various patient focused assessments and evaluations .