STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056229	A. BUILDING _____ B. WING _____	03/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM SPRINGS HEALTHCARE & REHABILITATION CENTER	277 S SUNRISE WAY PALM SPRINGS, CA 92262

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sufficient licensed nursing staff was available to provide care for ventilator dependent residents (artificial breathing machine needed to sustain life) and residents with tracheostomies (artificial airway placed in surgical opening in the neck) who were totally dependent on staff for their cares. This failure increased the potential for harm for all residents on the specialty unit. Findings: On February 11, 2020, at 1:41 p.m., the Department received an anonymous complaint with multiple concerns regarding the facility's subacute unit. On February 20, 2020, at 9:10 a.m., an unannounced visit was made to the facility for the investigation of the complaint. On February 20, 2020, at 9:30 a.m., a tour of the unit was done with Registered Nurse (RN) 1. Five of eleven residents on the unit were observed to be ventilator dependent, and all residents on the unit had artificial airways in place. The unit had enough beds to to admit up to 25 residents. Resident A was observed lying in bed, not alert, with a [MEDICAL CONDITION] connected to a ventilator. On February 20, 2020, at 9:30 a.m., RN 1 was interviewed and stated there was no Respiratory Therapist (professional trained to provide respiratory care/treatments including ventilator and [MEDICAL CONDITION] cares) on duty between 5 PM to 9 PM and 5 AM to 9 AM daily. RN 1 stated the RN on duty was responsible for the respiratory therapist duties when the RT was not there. RN 1 stated there was usually one RN on duty and no RT at the start of her shift. RN 1 was unsure how to answer when asked to describe the procedure to re-insert a resident's artificial airway if it became dislodged. RN 1 stated she had never had to do that. On February 20, 2020, at 9:50 a.m., RN 2 was interviewed and stated there were one to two RN's on duty for the day shift (7 AM to 3 PM). RN 2 stated if a resident's airway became plugged, and she was unable to clear it, she would call the RT. RN 2 stated if there was no RT on duty, she would call 911. RN 2 stated if there was an order to change the resident's ventilator settings, then she would call the RT on the telephone or have the Director of Nursing (DON) call the RT to come in. RN 2 stated the DON was not assigned only to the specialty, but supervised the skilled nursing facility also. When asked who relieved the RN on duty for meals, RN 2 stated if there was one RN on duty in the unit, they did not take a break during their shift. On February 20, 2020, at 10:05 a.m., RT 1 was interviewed and verified there was not an RT on duty in the unit 24 hours a day. RT 1 stated he thought the nurses could change the ventilator settings, but, the RT should do it. RT 1 stated RT training included two years of school, and a written and simulation board exam to be licensed. During a concurrent tour of the unit, no oxygen tank was observed ready to use at the bedside for 3 of the 5 ventilator dependent residents. RT 1 stated it was the RT's responsibility to make sure there was an oxygen tank at the bedside. The supply closet for the tanks was observed to be off the specialty unit, down two halls on the opposite side of the facility. On February 20, 2020, at 11:25 a.m., Resident A's record was reviewed and indicated Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On February 20, 2020, at 2:35 p.m., Licensed Vocational Nurse (LVN) 1 was interviewed and stated if a resident's airway became dislodged , she would call the RT to help. LVN 1 stated the facility reduced the number of hours the RTs were on duty recently because the unit census was low. When asked if the nurses were comfortable without an RT on duty, LVN 1 stated, I guess, and she would prefer to have an RT on duty. On February 20, 2020, at 2:50 p.m., Certified Nursing Assistant (CNA) 1 was interviewed and stated she was not allowed to touch the resident's airways or ventilators, and said she would call the RT or RN if she needed help. On February 20, 2020, at 3:12 p.m., the DON was interviewed and stated the RT staff was on-site 16 hours per day. The DON stated the nurses were not required to have prior experience on a subacute unit to work there. When asked about the nursing staffs' competency with ventilators, the DON stated competencies depended on the nurses' comfort level, and the nurses were not comfortable with the ventilator weaning process (removing a resident from ventilator for specified amounts of time to see how resident tolerates attempts to breathe on own). When asked who relieves the RN on duty for bathroom or meal breaks, the DON stated the RN's did not get meal breaks because the facility did not have coverage for the unit. On February 20, 2020, at 3:50 p.m., RN 3 was interviewed and stated when there was no RT on duty for the evening shift (3 p.m. to 11 p.m.), it did effect the RN's ability to complete cares including giving medications, IV's, and nebulizer (breathing) treatments. RN 3 stated the RN's needed to help the CNA staff lifting and turning residents if the resident was heavy and the CNA could not do it by themselves. On February 20, 2020, at 7 p.m., the staff roster for the unit was reviewed, and indicated the facility had three RNs to cover the evening shift and two RNs to cover the night shift (11 PM to 7 AM) in total. The evening shift staffing assignment sheets, dated January 25 through February 20, 2020, were reviewed, and indicated the RN on duty did not take a meal break for any shift. The staffing assignment sheets for the night shift, dated January 25 through February 20, 2020, were reviewed and indicated the RN on duty did not take a meal break for any shift. There were multiple night shifts with one RN and one CNA on duty. On February 21, 2020, at 1:07 p.m., a follow-up visit was made to the facility. On February 21, 2020, at 2:20 p.m., RT 2 was interviewed and stated resident emergencies on the unit included respiratory distress, decreased oxygen levels, ventilator alarms and disconnections. RT 2 stated if a resident's airway accidentally came partially or fully out, they would need to manually oxygenate the resident and re-insert the airway, and it would be optimal to have two staff present to do that. On February 27, 2020, at 1:30 p.m., Resident A's Medication Administration Record [REDACTED]. There were multiple entries on the MAR indicated [REDACTED]. The facility policy and procedure titled, Nurse-Patient Staffing Ratio and Subacute Staff Requirements dated August 2016 (before the unit was open), was reviewed and indicated, .It is the policy of this facility to provide services with sufficient staffing .to provide nursing care to all patients .in an environment which promotes each patient's .well-being . The facility policy and procedure titled, Troubleshooting the Ventilator System approved August 2016, was reviewed and indicated, Appropriate steps shall be taken to troubleshoot the ventilator system .Hazards .Malfunction .Disconnection .Airway obstruction .Retained secretions .The Respiratory Therapist shall .Assess the patient/resident .check .circuitry and ventilator .correct cause of alarm .If the patient/resident exhibits symptoms of artificial airway obstruction, take appropriate action immediately .identify the cause .Relieve the obstruction .Reestablish airway .ventilation .
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 observation, interview, and record review, the facility failed to ensure nursing staff had competent clinical skills to address potential emergencies and changes of condition for residents who were ventilator dependent (artificial breathing machine needed to sustain life) and had tracheostomies (artificial airway inserted into surgical opening in the

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) neck) on the specialty unit. This failure placed all residents on the unit at risk for harm, injuries, and/or death. Findings: On February 11, 2020, at 1:41 p.m., the Department received an anonymous complaint with multiple allegations regarding the competency of nurses and safety on the specialty unit. On February 20, 2020, at 9:10 a.m., an unannounced visit was made to the facility for the investigation of the complaint. On February 20, 2020, beginning at 9:30 a.m., a tour of the unit was conducted with Registered Nurse (RN) 1. Resident A was observed lying in bed, with an artificial airway connected to the ventilator, and not alert. When asked to describe what she would do if Resident A's artificial airway accidentally came out (a potentially fatal emergency) RN 1 stated she would keep the resident's airway open and ask for help, but was not able to specifically describe the procedure because she,never had to do it. When asked about the contents of the emergency airway kit, and whether an obturator (plastic guide used to re-insert airway) was kept at the bedside, RN 1 was unable to answer and was not familiar with the contents of the kit. RN 1 stated the RN was responsible when the RT was not on duty, and there was no Respiratory Therapist (RT) on duty at the start of the AM shift. On February 20, 2020, at 9:50 a.m., RN 2 was interviewed and asked to describe what she would do if a resident's artificial airway came out. RN 2 stated she would immediately re-insert the airway but was unable to specifically state a procedure. When asked, RN 2 was unable to state if an obturator was kept at the bedside and did not know what it was. RN 2 stated if she was unable to clear a plugged airway, she would call the RT. On February 20, 2020, at 10:05 a.m., RT 1 was interviewed and stated there was an RT on the unit from 9 AM to 5 PM and 9 PM to 5 AM each day. When asked if the nurses on the unit were able to change ventilator settings, RT 1 stated he thought they could but, the RT should do it. RT 1 stated they should keep at least one airway kit at each resident's bedside and each kit included cannulas (tube shaped airway piece) and an obturator. On February 20, 2020, beginning at 1:50 p.m., a sample of employee Human Resources (HR) files were reviewed and indicated: -RN 4 was a newly licensed RN on August 12, 2019, and had a hire date of September 5, 2019. RN 4's HR file indicated she graduated from nursing school eight years prior and had no clinical nursing experience before being hired to the specialty unit. There was no documented indication that RN 4 took a clinical refresher course or had any documented experience with ventilators or [MEDICAL CONDITION] care at the time of hire. The facility's RN job description did not indicate any respiratory care or ventilator related duties were required. The Orientation Time Sheet form included in RN 4's HR file was blank. On February 20, 2020, at 3:12 p.m., the DON was further interviewed and stated the nurses did not have to have prior experience working on a subacute unit (with ventilator dependent residents). The DON stated the nurses were given an initial eight hour class in-service on ventilator management and then in-serviced as needed after that. When asked if the nurses on the unit had concerns, the DON stated the nurses were not comfortable with the ventilator weaning process. On February 21, 2020, at 2:20 p.m., RT 2 was interviewed and stated resident emergencies on the unit included respiratory distress, decreased oxygen saturation levels, ventilator alarms and disconnections. RT 2 stated if a resident's artificial airway accidentally came partially or fully out, they would need to manually oxygenate the resident and re-insert the airway. RT 2 stated RT training to manage ventilators included three courses and five weeks of clinical hands-on training. On February 27, 2020, at 9:10 a.m., copies of the specialty unit nursing staff licenses and inservice certificates, provided by the facility, were reviewed and indicated 13 of the nurses assigned to the unit were given an in-service on ventilator care over three months prior to working on the unit, RN 4 was a newly licensed RN with no prior experience as listed above, LVN 2 was newly licensed 4 months prior, and LVN 3 was newly licensed. The facility policy and procedure titled, Staff Competency and Skills Evaluation undated, was reviewed and indicated, .All Registered Nurses, Licensed Vocational Nurses .will demonstrate subacute skills' specified competency before being placed to work in the .Unit . According to Title 22, CCR .5, Subacute Care Unit, each RN and LVN shall upon hire provide to the employer evidence of a minimum of six months experience within the past two years working in a general acute care facility (i.e. hospital or other facility caring for acutely ill patients) or an acquired equivalent competency appropriate to the type of patient the facility cares for. (The minimum number of hours an RN or LVN is typically required to be employed, and considered to be competent, in an acute care facility is 1 shift or 8-12 hours per week to maintain current nursing skills. Six months of acute care experience would be equivalent to 192-288 hours of direct patient care and would require nursing skills including how to handle emergencies, being familiar with equipment, and clinical assessment skills).
F 0836 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to verify that an outside consultant (OC) was a valid approved continuing education provider and keep accurate continuing education records for licensed nursing staff. This failure increased the potential for nursing staff to be out of compliance with licensing requirements while caring for residents at the facility. Findings: On February 20, 2020, at 9:10 a.m., an unannounced visit was made to the facility for the investigation of one complaint. On February 20, 2020, at 3:12 p.m., the Director of Nursing (DON) was interviewed and stated the nurses on the specialty unit were not required to have prior subacute experience caring for ventilator dependent residents. The DON stated (name of company) provided an eight hour in-service and orientation training for the licensed staff on the unit. On February 21, 2020, at 1:07 p.m., a follow-up visit was made to the facility for further investigation of the complaint. During a concurrent interview, the Staffing Coordinator for the unit stated the facility considered the nursing staff certified in ventilator dependent patient care after they completed the eight hour class. On February 21, 2020, at 1:50 p.m., Registered Nurse (RN) 5's Human Resources (HR) file was reviewed and indicated RN 5 had a hire date of [DATE]. The Continuing Education (CE) Certificate titled, Ventilator Management Course for License (sic) Nurses in the file indicated RN 5 completed the course [DATE] (9 months prior to her hire date). The Certificate indicated, Provider approved by the California Board of Registered Nursing Provider #([MEDICATION NAME]) for 8 Continuing education contact hours . The Certificate did not include RN 5's license number usually required. On February 24, 2020, at 8:21 a.m., The OC's CE provider #([MEDICATION NAME]) was checked on the California Board of Registered Nursing (BRN) website. The BRN website indicated the OC's continuing education provider status was delinquent and expired on [DATE]. The active staff roster for the specialty unit indicated there were 13 RNs and 9 Licensed Vocational Nurses assigned to the unit who were certified by the facility. The copies of the nurses CE Certificates indicated the nurses took the course from the OC between [DATE] and [DATE], and had various forms of the same course title with different provider signatures. On February 24, 2020, at 1:40 p.m., the Director of Staff Development (DSD) was interviewed and stated she was responsible for verifying staff nursing licenses and CE Certificates. The DSD stated the OC and another person came in to the facility and gave in-services to the licensed nurses and CNA staff. The DSD was unable to clearly state how to verify if a CE provider was valid and stated she did not verify whether the OC was approved. On [DATE], at 10:30 a.m., the Department recieved a message from the Board of Registered Nursing (BRN) staff that stated the OC obtained a new C.E provider number ([MEDICATION NAME]). According to the BRN verification website, the OC new provider number was issued [DATE]. It was unclear why the OC continued to issue CE certificates to the nursing staff using the expired/invalid CE provider number. According to 16 CCR 1451, regarding RN license renewal requirements, each licensed RN is required to submit proof of successful completion of 30 hours of approved continuing education during the preceeding two years to renew their RN license. According to the BRN, all RNs are required to complete the required continuing education to practice nursing in California. According to the Board of Vocational Nursing website, all LVNs are required to complete 30 hours of continuing education every two years to maintain an active license.