STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055873	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COMMUNITY CARE CENTER	**8665 LA MESA BLVD. LA MESA, CA 91942**

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 observation, interview, and record review, the facility failed to ensure professional standards of quality were provided for two of five sampled residents (1, 2) when: 1. Resident 1's physician's orders [REDACTED]. As a result, Resident 1 did not receive medication to treat his urinary tract infection for 17 hours. 2. Resident 2's physician's orders [REDACTED]. As a result, Resident 2's suture were in place 18 days post injury, and his right wrist fracture was not evaluated by an orthopedic doctor. Failure to follow physicians' orders resulted in delays in treatment, and the potential for physical and psychosocial harm due to complications from infection and injury. Findings: 1. Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 7/17/19, Resident 1's medical record was reviewed. According to the Resident Progress Notes, Resident 1 was sent to the hospital on [DATE] at 11:45 A.M., and returned to the facility on [DATE] at 7:43 P.M. On 7/6/19 at 12:27 P.M., a family member (FM) contacted the facility to inquire about the antibiotic medication ordered by the emergency department (ED) provider. The LN informed the FM no antibiotics had been entered into the EHR. According to the ED discharge instructions, dated 7/5/19, the provider ordered [MEDICATION NAME] 500 milligrams four times daily for seven days. According to the eMAR, Resident 1 received the first dose of the medication, obtained from the facility's emergency box, on 7/6/19 at 1 P.M., 17 hours after returning to the facility. On 7/17/19 at 3:25 P.M., Resident 1's medical record was reviewed with LN 1. LN 1 stated physician's orders [REDACTED]. LN 1 stated Resident 1's order should have been entered into the EHR and the pharmacy notified. LN 1 further stated the pharmacy would have included the medication in their next delivery, or authorized using the in-house emergency supply to begin treatment. On 7/17/19 at 3:55 P.M., LN 2 was interviewed. LN 2 stated he did not contact the ED after Resident 1 returned to the facility without discharge instructions. LN 2 further stated he did not notify the RN supervisor about Resident 1's return and the absence of follow up instructions. LN 2 was unable to explain how paperwork from the 7/5/19 ED visit was in the EHR. On 8/22/19 at 3:15 P.M., LN 3 was interviewed. LN 3 stated he was the RN supervisor on 7/5/19. LN 3 stated the expectation was the LN receiving a resident from the ED, or any outside provider, should call to confirm any discharge instructions. 2. Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 12/16/19, Resident 2's medical record was reviewed. According to the Resident progress notes, on 11/28/19, Resident 2 experienced a fall that resulted in a 6-centimeter laceration to the right 5th finger, and a fractured right distal ulna (inner arm bone at the wrist). Resident 2 was treated in the emergency department (ED) at the hospital. According to the hospital documentation, dated 11/28/19, Resident 2 required 11 sutures to close the finger wound. His right arm was placed in a plaster splint for support. The ED provider recommended suture removal in seven days, and a referral to an orthopedic doctor for his ulnar fracture. There was no evidence the ED provider's orders had been executed. On 12/16/19 at 10:10 A.M., Resident 2's health record was reviewed with LN 4. In addition to the ED orders, Resident 2's facility's physician's orders [REDACTED]. LN 4 stated there was no evidence an appointment had been scheduled, either in the health record or on the calendar. On 12/16/19 at 10:15 A.M., the CM was interviewed. The CM stated Resident 2's orders for suture removal and orthopedic appointment had not been entered into the electronic health record. On 12/16/19 at 11:50 A.M., the DON was interviewed. The DON stated the expectation was for all physicians' orders to be entered into the EHR to ensure appropriate care was given to the residents. According to the undated facility's policy, titled Physician order [REDACTED]. 2. Regardless of the participation status of the physician, all orders are entered into the electronic medical record to maintain continuity of care. According to the facility's policy, titled Medication and Treatment Orders, revised 7/2016, . 8. Verbal orders must be recorded immediately in the resident's chart

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE