STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055401	A. BUILDING _____ B. WING _____	**03/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOWBROOK HEALTH CARE CENTER	**461 E. JOHNSTON AVENUE HEMET, CA 92543**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing staff followed professional standards of care to intervene promptly when one of three sampled residents (Resident A) had a decline in condition and became unresponsive. This failure increased the potential for harm and may have caused delays in medical care and treatment for [REDACTED]. On February 3, 2020, at 2 p.m., an unannounced visit was made to the facility for the investigation of the complaints. During a concurrent interview, the Director of Nursing (DON) stated a nurse called her on [DATE], and told her then that Resident A did not look good, was non-responsive, and paramedics started CPR (Cardio-Pulmonary Resuscitation-emergency life saving measures) on the resident in the facility's parking lot. On February 3, 2020, beginning at 2:40 p.m., Resident A's record was reviewed and indicated Resident A was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The record indicated Resident A required [MEDICAL TREATMENT] (complex medical procedure to treat [MEDICAL CONDITION]) and [MED] (injectable medication to treat diabetes). Resident A's physician's orders [REDACTED].Full Treatment-primary goal of prolonging life by all medically effective means . Resident A's Care Plan, dated [DATE], indicated Resident A requested CPR and full treatment if emergency care was needed, and Resident A's oxygen saturations should remain above 92%. The Physician's Admitting Orders, dated [DATE] (untimed) indicated Resident A was to have his blood sugar checked 30 minutes before each meal and at bedtime daily; and, [MED] was to be administered if his blood sugars were above 151. The Nurse's Progress Notes, dated [DATE], at 6 p.m., were reviewed and indicated Resident A was readmitted to the facility alert and oriented with episodes of confusion, had stable vital signs, and was on oxygen at 3 liters per nasal cannula (small plastic tubing with prongs inserted into nose used to give low levels of oxygen). The Nurse's Progress Notes, dated [DATE], at 11 p.m., indicated Resident A was alert and verbally responsive, and had normal vital signs of heart rate 79/minute, respirations 20/minute, and blood pressure ,[DATE] (normal ranges heart rate ,[DATE]/minute, respirations ,[DATE]/minute, blood pressure 120-,[DATE]-90). The Nurse's Progress Notes, dated [DATE], at 2 p.m., indicated Resident A was very weak, required assistance with eating, was able to make his needs known, and had vital signs of heart rate 80, respirations 20, blood pressure ,[DATE]. The next Nurse's Note, dated [DATE], at 9:38 p.m., indicated Resident A was non-responsive (unable to respond to stimuli or environment) and his vital signs were markedly abnormal with heart rate 40/minute, respirations 32/minute, blood pressure low at ,[DATE], and oxygen saturation of 55% (normal oxygen level 90% or above-signs of potentially life threatening condition requiring emergency interventions). The Nurse's Notes further indicated, .CNA (Certified Nursing Assistant) advised me resident was non responsive when she tried to ask him if he was done with his dinner, I when (sic) to his room & I notice his V/S (vital signs) were like that .I raised the feet to see if that will help to elevated (sic) his B/P (blood pressure), I up his O2 to 5Lt (turned his oxygen up to 5 liters per minute) .immediately called 911 & they arrived right away .Paramedics took him for further evaluation . Resident A's Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. On February 3, 2020, at 3:50 p.m., Licensed Vocational Nurse (LVN) 1 was interviewed and stated she was on duty the evening Resident A became unresponsive. LVN 1 stated she checked his blood sugar which was a little high, gave his [MED], and went to pass medications to other residents. LVN 1 stated a CNA (unidentified) found Resident A unresponsive when she went to pick up his dinner tray. LVN 1 stated when she first tried to check Resident A's oxygen level, she could not get a reading, and his pulse was low. LVN 1 stated there was typically no Registered Nurse on duty during her shift; the DON was the facility's RN. LVN 1 stated when the paramedics arrived, they put an EKG on the resident (electrocardiogram, an electronic tracing of heart rate) and thought Resident A had an MI ([MEDICAL CONDITION]). On February 3, 2020, at 4:05 p.m., CNA 1 was interviewed and stated she was on duty when Resident A was found unresponsive. CNA 1 stated she woke Resident A up for dinner (typically served between 5 and 6 p.m.), he took a couple bites and was pocketing or placing food in his cheek. CNA 1 stated she took his dinner tray away and went to get another CNA to check Resident A with her. CNA 1 stated Resident A was clammy (cold/sweaty-a sign of shock or low blood sugar), cold to touch, and looked like he was sleeping. CNA 1 stated when she told the nurse on duty about Resident A, the nurse told her to go back and clean the resident up. CNA 1 stated when she changed Resident A, he did not respond and made a grunting noise. CNA 1 stated the nurse was passing medications and came to Resident A's room about 15 minutes later and told her to go answer the other call lights that were on. On February 4, 2020, at 1:50 p.m., the DON was interviewed and stated if the CNA staff found a resident unresponsive and the resident was full code, they should call for help, check the patient, prepare for the nurse, get the emergency cart , and call 911. The DON stated if a resident was unresponsive and breathing, the staff should check the resident's airway. On February 4, 2020, at 2:30 p.m., CNA 2 was interviewed and stated she was on duty when Resident A was unresponsive. CNA 2 stated when she took his dinner in to him, she asked him what was wrong with him, and when she went back in to pick up his dinner tray, he didn't look right. CNA 2 stated she did not check Resident A's vital signs, she told the nurse on duty. When asked what to do if the CNA finds a resident unresponsive, CNA 2 stated they should ask the resident if they are OK, and if the resident doesn't respond, they should call an emergency, stay with the person, and start CPR. CNA 2 stated she couldn't remember if the nursing staff called a Code Blue (alert to staff that resident needs CPR/emergency measures) when they found Resident A unresponsive. On February 4, 2020, at 2:45 p.m., the DON was further interviewed and stated if a Code Blue was called, all staff were supposed to respond. The DON stated Resident A was in respiratory distress, and the nurses turned his oxygen up. The DON stated LVN 1 told her Resident A's oxygen level improved after she elevated his feet and turned up the oxygen. There was no documentation in the record to support the LVN's statement. On February 4, 2020, at 3:30 p.m., LVN 2 was interviewed and stated she was on duty on the other side of the building when Resident A was unresponsive. LVN 2 stated LVN 1 came over and told her she needed someone to check on Resident A. LVN 2 stated LVN 1 checked Resident A's oxygen level, and LVN 2 didn't think they needed to call a Code Blue. LVN 2 stated Resident A's breathing was shallow and his pulse was concerning, it was all over the place. LVN 2 stated the nurses put oxygen on the resident and elevated the head of the bed. LVN 2 stated she didn't know what time it was, she didn't document when she checked Resident A because LVN 1 did, and she went out of the room to make copies of the record. On February 4, 2020, at 4:15 p.m., Resident A's records from (name of hospital) HOSP 1 were reviewed and indicated Resident A was admitted to HOSP 1 on [DATE], with [DIAGNOSES REDACTED]. Resident A's (name of ambulance transport company) Patient Care Report, dated [DATE], was reviewed, and indicated the facility called and reported Resident A was unconscious/[MEDICAL CONDITION] at 9:36 p.m. The Report indicated paramedics arrived at the resident's bedside at 9:44 p.m., and the resident was in critical condition, unresponsive, had decreased breath sounds, and was cool to touch. The Report indicated the paramedics inserted an artificial airway at 9:49 p.m. The Report further indicated, .Staff were unclear about pt's last seen normal (when the resident was last seen appearing normal). The nurse at scene reports finding the pt unconscious and hypoxic an hour prior to (paramedics) arrival. She reports noticing him with a

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

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) decreased LOC (level of consciousness) earlier in the sift (sic-shift) around dinner time. She reports that's when she knew something was wrong. By EMS arrival, pt was barely responsive to painful stimuli. His heart rate was rapid and irregular The Report further indicated the resident required oxygen at 15 liters per minute and bag mask ventilation (emergency procedure to assist breathing) en route to the HOSP 1. There was no documented indication that the LVN assigned to care for Resident A on [DATE], evening shift, checked or directed the CNA staff to check the resident's vital signs before 9:38 p.m. There was no documented indication the nursing staff checked or repositioned Resident A's airway to see if it was clear, attempted to give oxygen by mask at a higher rate to emergently increase his oxygen levels, or re-checked his vital signs or oxygen level after they were first taken at 9:38 p.m. There was no documented indication why the nurse on duty did not check Resident A's blood sugar at 4:30 p.m., as ordered, or again when he did not eat dinner. There was no documented indication what time the CNA staff initially noticed the change in the resident's condition, what time they found him unresponsive, or that the CNA staff checked Resident A's vital signs or initiated any emergency measures when they found the resident unresponsive. On February 18, 2020, at 1:05 p.m., the DON and Assistant Administrator (AADM) were interviewed. The DON stated the facility did not have an AED (automated electronic defibrillator-used to shock heart in emergency to restore normal rhythm), and the AADM acknowledged that the facility's nursing staff were required to have healthcare provider approved CPR certifications that included hands-on demonstration of skills. On [DATE], at 11:05 a.m., the DON was further interviewed and stated if a resident had blood sugar checks and sliding scale [MED] ordered four times daily, the nurses were supposed to check the resident's blood sugar half-hour before meals, and give the [MED] when the meal trays arrived on the floor. The DON stated dinner trays were served at 5 p.m., and usually picked up between 5:30 and 6 p.m. The DON stated if the resident's blood sugar was not checked, the nurse should document the reason in the nurse's notes or the back of the MAR. The facility policy and procedure titled, Emergency Procedure-Cardiopulmonary Resuscitation last revised [DATE], was reviewed and indicated, .Sudden [MEDICAL CONDITION] .is a leading cause of death in adults .Training .includes recognizing .atypical presentations .The goal of early delivery of CPR is to try to maintain life until the emergency medical response team arrives .if an individual is found unresponsive and not breathing normally, a licensed staff member who is certified .shall initiate CPR .Provide periodic Mock Codes (simulations of an actual arrest) for training purposes .CPR Team .shall include at least one registered nurse, one .LVN, and two CNAs .Begin CPR if the adult victim is unresponsive and not breathing normally .
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 ensure nursing staff documented according to professional standards for one of three sampled resident (Resident A) who required emergency interventions. This failure increased the potential for staff/providers to be uninformed about the resident's care and condition. Findings: On [DATE], and [DATE], the Department received two linked complaints with quality of care concerns regarding Resident A. On February 3, 2020, at 2 p.m., an unannounced visit was made to the facility for the investigation of the complaints. During a concurrent interview, the Director of Nursing (DON) stated a nurse called her on [DATE], and told her then that Resident A did not look good, was non-responsive, and paramedics started CPR (Cardio-Pulmonary Resuscitation-emergency life saving measures) on the resident in the facility's parking lot. On February 3, 2020, beginning at 2:40 p.m., Resident A's record was reviewed and indicated Resident A was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The record indicated Resident A required [MEDICAL TREATMENT] (complex medical procedure to treat [MEDICAL CONDITION]) and [MED] (injectable medication to treat diabetes). Resident A's physician's orders [REDACTED].Full Treatment-primary goal of prolonging life by all medically effective means . Resident A's Care Plan, dated [DATE], indicated Resident A requested CPR and full treatment if emergency care was needed. The Nurse's Notes, dated [DATE], at 9:38 p.m., indicated Resident A was non-responsive (unable to respond to stimuli or environment) and his vital signs were markedly abnormal with heart rate 40/minute, respirations 32/minute, blood pressure low at ,[DATE], and oxygen saturation of 55% (normal oxygen level 90% or above-signs of potentially life threatening condition requiring emergency interventions). The Nurse's Notes further indicated, .CNA (Certified Nursing Assistant) advised me resident was non responsive when she tried to ask him if he was done with his dinner, I when (sic) to his room & I notice his V/S (vital signs) were like that .I raised the feet to see if that will help to elevated (sic) his B/P (blood pressure), I up his O2 to 5Lt (turned his oxygen up to 5 liters per minute) . The handwritten Medication Administration Records (MARs) dated [DATE], were reviewed, and indicated Resident A was ordered to have blood sugar checks four times daily, and [MED] doses depending on the blood sugar levels. The area of the MARs where the nurses were supposed to write their signatures to identify which nurses gave medications to the resident was blank except for one signature. The MARs indicated no blood sugar was checked or [MED] given on [DATE], at 4:30 p.m., and the dose of [MED] given at 9 p.m., was not legible. There was no documented indication why the nurse on duty did not check Resident A's blood sugar at 4:30 p.m., as ordered, or again when he did not eat dinner. There was no documented indication what time the CNA staff initially noticed the change in the resident's condition or what time they initially found him unresponsive. There was no documented indication of LVN 2's evaluation of Resident A when LVN 1 asked her to check Resident A. On February 4, 2020, at 3:30 p.m., LVN 2 was interviewed and stated she was on duty on the other side of the building when Resident A was unresponsive. LVN 2 stated LVN 1 came over and told her she needed someone to check on Resident A. LVN 2 stated LVN 1 checked Resident A's oxygen level, and LVN 2 didn't think they needed to call a Code Blue. LVN 2 stated Resident A's breathing was shallow and his pulse was concerning, it was all over the place. LVN 2 stated the nurses put oxygen on the resident and elevated the head of the bed. LVN 2 stated she didn't know what time it was, she didn't document when she checked Resident A because LVN 1 did, and she went out of the room to make copies of the record. On [DATE], at 11:05 a.m., the DON was further interviewed and stated if a resident had blood sugar checks and sliding scale [MED] ordered four times daily, the nurses were supposed to check the resident's blood sugar half-hour before meals, and give the [MED] when the meal trays arrived on the floor. The DON stated dinner trays were served at 5 p.m., and usually picked up between 5:30 and 6 p.m. The DON stated if the resident's blood sugar was not checked, the nurse should document the reason in the nurse's notes or the back of the MAR. The facility policy and procedure titled, Charting and Documentation last revised [DATE], was reviewed and indicated, .All observations, medications, administered, services performed .must be documented in the resident's clinical records .All incidents .or changes in the resident's condition must be recorded .Documentation shall include .date and time the .treatment was provided .unusual findings .How the resident tolerated .treatment .