STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055409	A. BUILDING _____ B. WING _____	**05/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COMMUNITY CARE AND REHABILITATION CENTER	**4070 JURUPA AVENUE RIVERSIDE, CA 92506**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, for one of three sampled residents (Resident A), the resident's family member (FM) was notified of the resident's change of condition (COC), when the resident developed respiratory wheezing (high-pitched [MEDICATION NAME] sounds made while breathing, usually caused by narrowed airways or inflammation) and chest congestion (build-up of fluids in the lungs). This failure increased the potential for the resident's responsible party and family members to not be aware or involved in Resident A's condition and the provision of care. Findings: On February 24, 2020, at 1:07 p.m., Resident A's FM was interviewed and stated the resident was initially admitted to the facility for further medical care and management. She stated the resident was on tube feeding and was on a do not resuscitate status (DNR- also known as no code or allow natural death, is a legal order, indicating that a person does not want to receive cardiopulmonary resuscitation (CPR) if that person's heart stops beating). She stated the family wanted to keep the resident comfortable, but stated that staff were told that if (Resident A) gets worse, (the staff should) notify us (family) . She stated the resident had a gastrostomy tube ([DEVICE]- a tube inserted through the belly that brings nutrition directly to the stomach), and received tube feedings for two years. On February 24, 2020, at 9:06 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to quality of care concerns. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The history and physical, dated [DATE], indicated the resident did not have the capacity to understand and make decisions. The Resident Admission Assessment, dated [DATE], indicated, .Respiratory System: breath sounds: clear .respiration: regular . A physician's orders [REDACTED]. May suction patient PRN for increase in oral secretions. The nurses' notes indicated the following: - [DATE], at 7:30 a.m., Resident noted with chest congestion/wheezing. MD (physician) (was) paged, awaiting call back. Endorsed to AM (morning shift: 7 a.m. to 3 p.m.) nurse . - [DATE], late entry for 3:00 p.m., .During rounds with NOC (11 p.m. to 7 a.m.) shift nurse, resident noted with some wheezing and slight gurgling .received new order for [MEDICATION NAME] .related to congestion, wheezing, and an order for [REDACTED]. - [DATE], late entry for PM shift (3 p.m. to 11 p.m.), Resident awake in bed resting @ (at) 1500 (3 p.m.) . Upon auscultation (use of stethoscope to listen to breath sounds) (of the) lungs, resident noted with faint wheezing sounds with congestion, no cough noted, head of bed elevated . Post breathing tx, resident had decreased wheezing and congestion . There was no documented evidence the resident's responsible party was notified of the COC. On February 25, 2020, at 12:18 p.m., Resident A's record was reviewed with the Director of Nursing (DON) and confirmed there was no documentation in the clinical record that the responsible party was notified when the resident had a COC of wheezing and congestion on [DATE]. When asked about the facility's policy on COC notification, she stated the licensed staff should notify the family for any change in the resident's condition. The facility's policy and procedure titled, Change in a Resident's Condition or Status, dated [DATE], indicated: Our facility shall promptly notify the resident, his or her attending physician, and representative .of changes in the resident's medical/mental condition and/or status. .Unless otherwise instructed by the resident, the nurse supervisor/charge nurse will notify the resident's next-of-kin or representative (sponsor) when .there is a significant change in the resident's physical, mental, or psychosocial status .
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 develop a plan of care with specific goals and objectives to address the change in a resident's condition, for one of three sampled residents (Resident A), when the resident developed respiratory wheezing (high-pitched [MEDICATION NAME] sounds made while breathing, usually caused by narrowed airways or inflammation) and chest congestion (build-up of fluids in the lungs). This failure increased the potential to result in inconsistent and inadequate provision of care for Resident A. Findings: On February 24, 2020, at 9:06 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to quality of care concerns. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The history and physical, dated January 20, 2020, indicated the resident did not have the capacity to understand and make decisions. The Resident Admission Assessment, dated January 19, 2020, indicated, .Respiratory System: breath sounds: clear .respiration: regular . A physician's orders [REDACTED]. May suction patient PRN for increase in oral secretions. The nurses' notes indicated the following: - January 29, 2020, at 7:30 a.m., Resident noted with chest congestion/wheezing. MD (physician) (was) paged, awaiting call back. Endorsed to AM (morning shift: 7 a.m. to 3 p.m.) nurse . - January 29, 2020, late entry for 3:00 p.m., .During rounds with NOC (11 p.m. to 7 a.m.) shift nurse, resident noted with some wheezing and slight gurgling .received new order for [MEDICATION NAME] .related to congestion, wheezing, and an order for [REDACTED]. - January 29, 2020, late entry for PM shift (3 p.m. to 11 p.m.), Resident awake in bed resting @ (at) 1500 (3 p.m.) . Upon auscultation (use of stethoscope to listen to breath sounds) (of the resident's) lungs, resident noted with faint wheezing sounds with congestion, no cough noted, head of bed elevated . Post breathing tx, resident had decreased wheezing and congestion . There was no care plan developed to address the resident's change of condition (wheezing and congestion). On February 25, 2020, at 12:18 p.m., Resident A's record was reviewed with the Director of Nursing (DON) and confirmed there was no care plan in the clinical record to address the resident's change of condition on January 29, 2020, when the resident had an identified respiratory problem. When asked about the facility's policy on change of condition, she stated a care plan should be developed to address the change in the resident's condition. The facility's policy and procedure titled, Goals and Objectives, Care Plans, dated January 2020, indicated: .Care plan goals and objectives are defined as the desired outcome for a specific resident problem . When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established . Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved.

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.