STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056185	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF MENIFEE	27600 ENCANTO DRIVE SUN CITY, CA 92586

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 a treatment was provided for one of four sampled residents' (Resident 1) excoriation of the sacral area. This failure had the potential to result in resident not receiving the necessary treatment which could result in worsening of Resident 1's skin condition. Findings: On January 4, 2020, at 9:50 a.m., an unannounced visit was conducted to investigate a quality of care issue. Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician order [REDACTED]. The progress notes titled Skin/Wound Note, indicated the following: a. On January 13, 2020, .Coccyx (bone below the sacrum (bone at the base of the spine)) excoriation 3.0 x (by) 0.3 with no drainage noted .; and b. On January 26, 2020, .Then proceed with coccyx tx (treatment), excoriation on coccyx is still present, no drainage noted, no odor, or slough noted, coccyx excoriation with 100% granulation wound base, beefy red . There was no treatment order for Resident 1's excoriation of the coccyx. The progress notes dated January 24, 2020, indicated, .At approximately 1300 (1 p.m.) 911 (emergency ambulance) arrived .Resident left facility . The (acute care hospital) Emergency Department (ED) Record dated January 24, 2020, indicated, Resident 1 was assessed on January 24, 2020, at 6:09 p.m. (five hours after the transfer), having multiple pressure ulcers. Resident 1 had Stage 2 pressure ulcer (topmost layer of the skin was broken) on left sacrum and deep tissue injury (pressure related injury under intact skin) on the left heel. The (acute care hospital) Wound Report, dated January 26, 2020, indicated, .Community Acquired Stage (present on day 1 of the resident's stay) II to coccyx/sacrum region . On January 11, 2020, at 10:12 a.m., the Treatment Nurse (TN) was interviewed. The TN stated she assessed residents for presence of skin problems the day after admission. She stated she would describe the wound and would provide treatment as prescribed by the physician. The TN stated Resident 1 had excoriation on the coccyx area upon admission. In a concurrent review of Resident 1's treatment order, the TN stated the treatment was for skin redness on the buttocks and periarea. The TN stated there was no treatment for [REDACTED]. The TN stated she continued the treatment provided by the hospital on transfer. The TN further stated she reassessed Resident 1's skin before the transfer. The TN stated the wound worsened and bigger. On January 11, 2020, at 10:57 a.m., the Director of Nursing (DON) was interviewed. The DON stated Resident 1 had excoriation of the coccyx on admission. The DON stated Resident 1's treatment order was for redness of buttocks and periarea, not for excoriation of the coccyx. The DON stated the treatment nurse should have clarified the treatment order on admission. The DON stated the TN should have verified with the physician if the present treatment was applicable for coccyx excoriation.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the amount of enteral feeding (intake of food via the gastrointestinal (GI) tract) administered was consistent with the physician order [REDACTED]. Findings: On February 4, 2020, at 8:50 a.m., an unannounced visit was conducted at the facility to investigate a quality of care issue. 1. On January 4, 2020, at 10:21 a.m., Resident 2 was observed in bed. The enteral pump beside the resident was turned off. No enteral feeding was observed being administered to Resident 2. Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the physician order [REDACTED]. OFF at 800 AM, ON at 1200 PM. The care plan dated January 25, 2020, indicated, Focus: The resident requires G (gastrostomy - opening into the stomach from the abdominal wall) tube feeding r/t (related to) aspiration PNA (pneumonia - lung infection that develops after food or liquid is inhaled into the lungs) and Dysphagia and is NPO (nothing by mouth) .Intervention .The resident is dependent with tube feeding and water flushes. See MD (Medical Doctor) orders for current feeding orders . On January 4, 2020, at 3:57 p.m., Licensed Vocational Nurse (LVN) 2 was interviewed. She stated Resident 2's feeding started at 12 noon and should be administered continuously. On January 4, 2020, at 4:11 p.m., the Physical Therapist (PT) was interviewed. The PT stated there were times Resident 2's feeding was disconnected during therapy. On January 4, 2020, at 4:17 p.m., LVN 2 was asked how much feeding was administered to Resident 2. LVN 2 stated the feeding pump would indicate the amount administered to the resident. She stated she could not tell the amount since the licensed nurse who hanged the enteral feed did not clear the feeding pump. She stated the feeding pump should have been cleared to know the amount being delivered from time to time. On January 4, 2020, at 4:30 p.m., a concurrent observation and interview with the Director of Nursing (DON) was conducted. The DON stated the enteral feeding could be interrupted as long as the required amount of feeding would be completed. The DON stated Resident 2 should have 1800 ml of enteral feed from 12 noon to eight in the morning. The DON checked on Resident 2's feeding pump, and the feeding pump indicated an amount of 1706 ml. The DON stated the enteral feeding administered to Resident 2 was not completed. The DON stated even if the feeding pump was not cleared it should have indicated more than 1800 ml at this time. 2. On January 11, 2020, at 9:11 a.m., Resident 4 was observed in bed. Resident 4's enteral tube feeding was observed not connected to Resident 4. Resident 4's record was reviewed. Resident 4 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician order [REDACTED].{[MEDICATION NAME] 1.2} at 75 ml/(per)hour x (for) 18 hours via (by) pump GT Start Time 12:00 PM and Off 6:00 AM OR UNTIL DOSE IS COMPLETED to provide 1350L (liters)/1620cal. The care plan dated July 29, 2019, indicated, .requires GT feeding r/t (related to) MS ([MEDICAL CONDITION] - disease that affect the brain, spinal cord) with dysphagia .The resident is dependent with tube feeding and water flushes. See MD (Medical Doctor) orders for current feeding orders . On January 11, 2020, at 9: 13 a.m., Licensed Vocational Nurse (LVN) 3 was interviewed. LVN 3 stated she was the licensed nurse for Resident 4. She stated Resident 4 was on enteral feeding from 12 noon and to run for 18 hours. LVN 3 stated the amount administered to Resident 4 was at 1250 ml when the feeding was discontinued. She stated the amount delivered should be at 1350 ml. LVN 3 stated Resident 4 was showered this morning but the feeding should have been connected and infused when Resident 4 came back from shower. LVN 4 stated the amount administered to Resident 4 was not the amount prescribed by the physician. On January 11, 2020, at 12:32 p.m., the Director of Nursing (DON) was interviewed. The DON stated the licensed nurse should know how to operate the feeding pump. The DON stated the practice for enteral feeding was for licensed nurse to clear the feeding pump when starting the enteral feed. The DON stated before the start of a dose, the feeding pump should be at 0 ml, to better assist the licensed nurses in tracking the amount of the resident's enteral feed.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on observation, interview, and record review, the facility failed to ensure the oxygen was administered continuously and within the prescribed oxygen level, for one of four sampled residents (Resident 2), . This failure had the potential for the resident not to receive the appropriate oxygen required for his medical condition which could result in respiratory complications. Findings: On February 4, 2020, at 8:50 a.m., an unannounced visit to the facility was conducted to investigate a quality of care issue. On February 4, 2020, at 10:21 a.m., Resident 2 was observed sleeping. Resident 2's nasal cannula was observed not attached to the resident's nostrils. In addition, the oxygen tubing was not attached to the oxygen concentrator. The oxygen concentrator was at 4 liters per minute. On February 4, 2020, at 10:22 a.m, the Director of Staff Development (DSD) was observed fixing Resident 2's nasal cannula and stated oxygen is not on you. In a concurrent interview with the DSD, the DSD acknowledged that the nasal cannula was not attached to Resident 2's nostrils and the oxygen tubing was not attached to the oxygen concentrator. On February 4, 2020, at 11:05 a.m., Certifed Nursing Assistant (CNA) 1 was interviewed. CNA 1 stated she last saw Resident 2 at 9 a.m. CNA 1 stated Resident 2's oxygen should be administered continuously and should not be left disconnected. CNA 1 was asked about the oxygen level of Resident 2, CNA 1 stated the oxygen level was at 4 liters per minute. Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The care plan dated January 22, 2020, indicated, Infection (PNA) .Interventions .O2 at 2L/min via nasal cannula as ordered . On February 4, 2020, at 11:09 a.m., a concurrent interview and record review of Resident 2's record was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated the physician order [REDACTED]. LVN 1 stated she was not aware the oxygen level for Resident 1 was at 4 liters per minute. LVN 1 stated the oxygen level should be at 2 liters per minute as per physician's orders [REDACTED]. The DON stated she was informed by the licensed nurse that Resident 2's oxygen saturation was low between 6 a.m. and 7 a.m. in the morning. Resident 2's doctor was informed and ordered to increase oxygen level to 4 liters per minute. The DON stated the licensed nurse should have changed the physician's orders [REDACTED]. The DON further stated Resident 2 had a change of condition and the change of condition should have been documented. The DON stated there was no documentation of Resident 2's change of condition. The policy and procedure titled, Oxygen administration, dated November 15, 2019, was reviewed. The policy and procedure indicated, .Implementation .Verify the practitioner's order for oxygen therapy, because oxygen is considered a medications or therapy and requires a prescription .Help place the oxygen delivery device on the patient. Make sure that it fits properly and is stable .