STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555623	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEMET VALLEY HEALTHCARE CENTER	371 NORTH WESTON PL 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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the results of the facility's investigation of an allegation of abuse was reported to [ST] Department of Public Health (CDPH) within five working days of the occurrence of the alleged abuse incident, for one of three residents reviewed (Resident A). This failure had the potential to result in a delay in the implementation of the intervention to ensure Resident A's safety and may place the residents at risk for further abuse. Findings: On January 30, 2020, at 1:40 p.m., an unannounced visit to the facility was conducted to investigate an allegation of abuse. On January 30, 2020, at 2:13 p.m., the Assistant Director of Nursing was interviewed. The ADON stated the allegation of abuse happened on January 17, 2020, at around 5 a.m., when Resident A alleged Licensed Vocational Nurse (LVN) 1 hit her face with a bottle of medications. She stated LVN 1 told her she gave the medication to Resident A on January 17, 2020, at around 5 a.m., and tried to wake Resident A up to administer the medication. She stated LVN 1 told her she knocked on the door and at the bed side table until Resident A woke up and was able to take the medication. She stated she was not aware of the conclusion of the investigation of the allegation of abuse as the facility Human Resources Department (HRD) took over the investigation. She stated she was not aware the facility had to report the results of the investigation to CDPH within five working days of the occurrence of the allegation of abuse. On January 30, 2020, Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The History and Physical, dated January 14, 2020, indicated Resident A was mentally capable of understanding. The Nursing Notes, dated January 17, 2020, at 8:30 a.m., indicated, .Patients (sic) (FM, family member) came into facility really angry and wanted to take (the resident) out of facility.As security went in room he asked patient's (FM) what the problem was she stated that she got a phone call this morning from (the resident) stating she was woken up by the nurse by being slapped in the face with a bottle of pills.Nurse stated she was giving the patient her morning meds (medications) and was having to wake her up to take the medications. On February 4, 2020, at 10:03 a.m., the Quality Director (QD) was interviewed. The QD stated the facility should conduct the investigation, coordinated findings, and determined if an allegation of abuse was substantiated or not. She stated the final investigation should be determined by the facility designee and the written report was to be provided to CDPH within five working days. She stated the facility was not able to report the result of the final investigation of the allegation of abuse to CDPH until February 4, 2020 (12 working days from the date of occurrence of the alleged abuse). She stated the facility should have provided CDPH a final report of the investigation of the allegation of abuse within five working days of the occurrence of the allegation of abuse. The facility policy and procedure titled, ABUSE, PROHIBITION OF; TRAINING, INVESTIGATING AND REPORTING, revised October 2018, was reviewed. The policy indicated, .To provide a method for the prevention of any type of dependent adult or elderly abuse/neglect/exploitation and to identify and appropriately report any actual or suspected dependent adult or elderly abuse/neglect/exploitation.Upon completion of the investigation of the suspected or alleged abuse, but in no instance more than five (5) working days after the incident, the Chief Hospital Executive Officer/Chief Nursing Officer or designee shall report the results of the investigation to the Department of Public Health, local law enforcement and the long-term care ombudsman.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pharmaceutical services were provided to meet the needs of a resident, when [MED] (medication to treat or prevent blood clots) was not acquired by the facility timely, for one of three residents reviewed (Resident B). This failure had the potential to result in a delay in the treatment and the development of complications for Resident B. Findings: On January 30, 2020, at 4:56 p.m., Resident B was observed lying in bed and awake. Resident B was observed to have a dressing on her left hand/fingers. On January 30, 2020, Resident B's record was reviewed. Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The PHYSICIAN ADMITTING ORDERS, dated January 21, 2020, included an order, .[MED] tab (tablet) 5 mg (milligram - unit of measurement) PO (by mouth) every 12 hours. [MEDICAL CONDITION] ([MEDICAL CONDITION] - blood clot) [MEDICATION NAME] (prevention). The untitled document, for January 2020, indicated the licensed nurses' (LN) initials were encircled on the following dates and times for [MED]: - January 23, 2020, at 5 p.m.; - January 24, 2020, at 5 p.m.; - January 25, 2020, at 9 a.m., and at 5 p.m.; - January 26, 2020, at 9 a.m., and at 5 p.m.; and - January 27, 2020, at 5 p.m. The back page of the untitled document, for January 2020, included nurse's notes which indicated [MED] was not administered to Resident B for the following reasons on the following dates and times: - January 23, 2020, at 5 p.m.; awaiting supply from pharmacy; - January 25, 2020, at 9:00 a.m.; awaiting on pharmacy; and - January 27, 2020, at 5 p.m; not available. There was no documented evidence of the reason for encircling the LNs' initials on the following dates and times: - January 24, 2020, at 5 p.m.; - January 25, 2020, at 5 p.m.; - January 26, 2020, at 9 a.m., and at 5 p.m.; and The [MED] was signed as administered on the following dates and times: - January 22, 2020, at 9 a.m.; - January 23, 2020, at 9 a.m.; - January 24, 2020, at 9 a.m.; - January 27, 2020, at 9 a.m.; - January 28, 2020, at 9 a.m. and 5 p.m.; - January 29, 2020, at 9 a.m. and 5 p.m.; and - January 30, 2020, at 9 a.m. On January 30, 2020, at 5:01 p.m., Resident B's record was reviewed with the Assistant Director of Nursing (ADON). The ADON stated when the licensed nurse encircled their initials on a resident's medication record, it meant the medication was not administered. She stated the LN should indicate at the back of the medication record the reason why the medication was not administered. She stated the LNs encircled their initial for [MED] on January 23, 24, 25, 26, and 27, 2020. She stated the [MED] was not administered to Resident B on those days as the facility was waiting for the medication to be delivered by pharmacy. She stated the LNs should have followed up with the pharmacy on the status of Resident B's [MED] delivery. She stated the LNs should have notified the physician [MED] was not administered to Resident B, on those dates due to its unavailability. On February 4, 2020, at 10:56 a.m., a of the pharmacy delivery receipts and Resident B's medication record for January and February 2020, was conducted with the ADON. The document titled, DELIVERY MANIFEST, dated January 21, 22, 28, 29, and 30, 2020, included medications which were delivered for Resident B. There was no documented evidence [MED] was delivered to the facility on [DATE], 28, 29, and 30, 2020. The untitled document, for January 2020, indicated the LNs' initials were encircled on January 31, 2020, at 9 a.m. and 5 p.m. for [MED]. The untitled document, for February 2020, indicated the LNs' initials were encircled on February 1 through 4, 2020, at 9 a.m. for [MED]. The document also indicated the LN's initial was encircled on February 1 to 3, 2020, at 5 p.m. for [MED]. The back page of

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

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HEMET VALLEY HEALTHCARE CENTER	371 NORTH WESTON PL HEMET, CA 92543

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) the untitled document, for January and February 2020, included nurse's notes which indicated [MED] was not administered to Resident B for the following reasons on the following dates and times: - January 31, 2020, at 9 a.m.; not available; - Feburary 1, 2020, at 9 a.m.; awaiting for pharmacy; - February 2, 2020, at 8 a.m.; awaiting pharmacy; - February 3, 2020, at 5 p.m.; awaiting for pharmacy; and - February 4, 2020, at 9:30 a.m.; awaiting for pharmacy. In a concurrent interview with the ADON, she stated she inspected the medication cart on February 4, 2020, and there was no supply of [MED] for Resident B. She stated Resident B's [MED] was not administered to the resident on January 31 through February 4, 2020, due to the medication's unavailability. She stated there was no documentation the supply of [MED] for Resident B was followed up with the pharmacy. She stated the facility should have followed up with the pharmacy regarding the delivery of [MED] for Resident B. On February 4, 2020, at 11:27 a.m., a concurrent interview and record review were conducted with Licensed Vocational Nurse (LVN) 2. She stated she remembered there were several medications pharmacy had not delivered for Resident B but she was not certain of which medication was it. She stated she signed Resident B's [MED] as administered for the 9 a.m. dose on January 22, 23, 24, 27, 28, 29, and 30, 2020. She stated she had signed the [MED] as administered but she was not able to administer the medication. She stated she should have encircled her initials in the Medication Administration Record [REDACTED]. On February 4, 2020, at 11:29 a.m., the Director of Pharmacy (DP) was interviewed. The DP stated the pharmacy received the order of [MED] for Resident B on January 22, 2020, at 7:21 a.m. She stated on January 22, 2020, at 8:30 a.m., the pharmacy staff talked to Registered Nurse (RN) 1 and informed her to change [MED] to [MEDICATION NAME] (medication used for blood clots) due to a drug interaction with another medication of Resident B. She stated Resident B's [MED] was not delivered to facility since January 21, 2020. She stated there was no follow up made by the pharmacy staff regarding the recommendation to refer to the physician to change the [MED] to [MEDICATION NAME] after January 22, 2020 (11 days after the recommendation was given to the facility). She stated the pharmacy should have followed up with the facility every day on the status of the [MED] recommendation. She stated the facility and the pharmacy should work together for the resident to receive the necessary care. She stated Resident B could develop blood clots if [MED] was not administered to the resident. The undated facility policy and procedure titled, Pharmacy Policy and Procedure Medication Drug Regimen Review Upon Admission and Medication Changes, was reviewed. The policy indicated, .The dispensing pharmacist upon patient admission or medication order change will evaluate for clinically significant drug interactions.This course of action will include communication to the resident's nurse via fax (telephonic communication) or phone to promptly resolve the medication issue and be documented for the facility using the Medication Regimen Review form.Nurse to notify/follow up with prescriber and communicate changes to the pharmacy.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure [MED] (medication used to prevent blood clots) was administered as ordered by the physician, for one of three residents reviewed (Resident B). This failure had a potential to result in a delay in treatment and in the development of complications, such as blood clots, for Resident B. Findings: On January 30, 2020, at 4:56 p.m., Resident B was observed lying in bed and awake. Resident B was observed to have a dressing on her left hand/fingers. On January 30, 2020, Resident B's record was reviewed. Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The PHYSICIAN ADMITTING ORDERS, dated January 21, 2020, included an order, .[MED] tab (tablet) 5 mg (milligram - unit of measurement) PO (by mouth) every 12 hours. [MEDICAL CONDITION] ([MEDICAL CONDITION] - blood clot) [MEDICATION NAME] (prevention). The untitled document, for January 2020, indicated the licensed nurses' (LN) initials were encircled on the following dates and times for [MED]: - January 23, 2020, at 5 p.m.; - January 24, 2020, at 5 p.m.; - January 25, 2020, at 9 a.m., and at 5 p.m.; - January 26, 2020, at 9 a.m., and at 5 p.m.; and - January 27, 2020, at 5 p.m. The back page of the untitled document, for January 2020, included nurse's notes which indicated [MED] was not administered to Resident B for the following reasons on the following dates and times: - January 23, 2020, at 5 p.m.; awaiting supply from pharmacy; - January 25, 2020, at 9:00 a.m.; awaiting on pharmacy; and - January 27, 2020, at 5 p.m; not available. There was no documented evidence of the reason for encircling the LNs' initials on the following dates and times: - January 24, 2020, at 5 p.m.; - January 25, 2020, at 5 p.m.; - January 26, 2020, at 9 a.m., and at 5 p.m.; and The [MED] was signed as administered on the following dates and times: - January 22, 2020, at 9 a.m.; - January 23, 2020, at 9 a.m.; - January 24, 2020, at 9 a.m.; - January 27, 2020, at 9 a.m.; - January 28, 2020, at 9 a.m. and 5 p.m.; - January 29, 2020, at 9 a.m. and 5 p.m.; and - January 30, 2020, at 9 a.m. On January 30, 2020, at 5:01 p.m., Resident B's record was reviewed with the Assistant Director of Nursing (ADON). The ADON stated when the licensed nurse encircled their initials on a resident's medication record, it meant the medication was not administered. She stated the LN should indicate at the back of the medication record the reason why the medication was not administered. She stated the LNs encircled their initial for [MED] on January 23, 24, 25, 26, and 27, 2020. She stated the [MED] was not administered to Resident B on those days as the facility was waiting for the medication to be delivered by pharmacy. She stated the LNs should have followed up with the pharmacy on the status of Resident B's [MED] delivery. She stated the LNs should have notified the physician [MED] was not administered to Resident B, on those dates due to its unavailability. On February 4, 2020, at 10:56 a.m., a review of the pharmacy delivery receipts and Resident B's medication record for January and February 2020, was conducted with the ADON. The document titled, DELIVERY MANIFEST, dated January 21, 22, 28, 29, and 30, 2020, included medications which were delivered for Resident B. There was no documented evidence [MED] was delivered to the facility on [DATE], 28, 29, and 30, 2020. The untitled document, for January 2020, indicated the LNs' initials were encircled on January 31, 2020, at 9 a.m. and 5 p.m. for [MED]. The untitled document, for February 2020, indicated the LNs' initials were encircled on February 1 through 4, 2020, at 9 a.m. for [MED]. The document also indicated the LN's initial was encircled on February 1 to 3, 2020, at 5 p.m. for [MED]. The back page of the untitled document, for January and February 2020, included nurse's notes which indicated [MED] was not administered to Resident B for the following reasons on the following dates and times: - January 31, 2020, at 9 a.m.; not available; - Feburary 1, 2020, at 9 a.m.; awaiting for pharmacy; - February 2, 2020, at 8 a.m.; awaiting pharmacy; - February 3, 2020, at 5 p.m.; awaiting for pharmacy; and - February 4, 2020, at 9:30 a.m.; awaiting for pharmacy. In a concurrent interview with the ADON, she stated she inspected the medication cart on February 4, 2020, and there was no supply of [MED] for Resident B. She stated Resident B's [MED] was not administered to the resident on January 31 to February 4, 2020, due to the medication's unavailability. She stated there was no documentation the supply of [MED] for Resident B was followed up with the pharmacy. She stated the facility should have followed up with the pharmacy regarding the delivery of [MED] for Resident B. On February 4, 2020, at 11:27 a.m., a concurrent interview and record review were conducted with Licensed Vocational Nurse (LVN) 2. She stated she remembered there were several medications pharmacy had not delivered for Resident B but she was not certain of which medication was it. She stated she signed Resident B's [MED] as administered for the 9 a.m. dose on January 22, 23, 24, 27, 28, 29, and 30, 2020. She stated she had signed the [MED] as administered but she was not able to administer the medication. She stated she should have encircled her initials in the Medication Administration Record [REDACTED]. On February 4, 2020, at 11:29 a.m., the Director of Pharmacy (DP) was interviewed. The DP stated the pharmacy received the order of [MED] for Resident B on January 22, 2020, at 7:21 a.m. She stated on January 22, 2020, at 8:30 a.m., the pharmacy staff talked to Registered Nurse (RN) 1 and informed her to change [MED] to [MEDICATION NAME] (medication used for blood clots) due to a drug interaction with another medication of Resident B. She stated Resident B's [MED] was not delivered to facility since January 21, 2020. She stated there was no follow up made by the pharmacy staff regarding the recommendation to refer to the physician to change the [MED] to [MEDICATION NAME] after January 22, 2020 (11 days after the recommendation was given to the facility). She stated the pharmacy should have followed up with the facility every day on the status of the [MED] recommendation. She stated the facility and the pharmacy should work together for the resident to receive the necessary care. She stated Resident B could develop blood clots if the [MED] was not administered to the resident. She stated the physician was not notified [MED] was not administered to Resident B from January 21 to February 4, 2020 (14 days long). She stated the physician should have been notified [MED] was not administred to Resident B due to its unavailability. The facility policy and procedure titled, Medication Administration, revised April 2016, was reviewed. The policy indicated,.Medication will be administered upon the order of a physician.The licensed nurse will notify the attending licensed healthcare practitioner of the facility's inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies or services as prescribed under conditions which present a risk to the health, safety or security of the patient.Medication Errors.Medication is considered to be given in error if any of the following conditions are present.Omission (not administered) of a dose.When timed medications are not given, the time box designated on the MAR (medication administration record) is circled and the reason is indicated.

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F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2)