STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055255	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORONA HEALTH CARE CENTER	**1400 CIRCLE CITY DRIVE CORONA, CA 92879**

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 resident was provided the services and/or treatment in accordance with professional standards of practice when a procedure was performed without a physician's order, for one of three residents (Resident 1). This failure had the potential for Resident 1 to receive unnecessary treatment and/or procedures. Findings: On February 13, 2020, at 8:14 a.m., an unannounced visit was conducted to investigate a facility reported incident. On February 13, 2020, at 8:16 a.m., the Director of Nursing (DON) was interviewed. She stated Resident 1's rectal tube was reinserted at the facility on February 10, 2020. On February 13, 2020, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Order Summary Report, dated February 7, 2020, indicated, .Rectal Tube (a plastic tube connected to a bedside drainage bag for collection of stool) - Monitor for any s/s (signs and symptoms) of infection and tube care every shift for Wound Management . The history and physical examination [REDACTED]. The Progress Notes, dated February 12, 2020, at 7:49 a.m., indicated, .tx (treatment nurse) and cna (certified nursing assistant) slowly repositioned pt (patient) at which time pt stated, Watch out for my rectal tube, it hurts its been hurting since they changed it not last night but the night before . The untitled document, dated February 13, 2020, at 8:28 a.m., indicated, Rectal tube in place for wound management. Change PRN (as needed) if tube is dislodged or not draining. There was no documented evidence the physician ordered Resident 1's rectal tube to be changed prior to February 12, 2020. On February 13, 2020, at 8:51 a.m., Resident 1 was interviewed. She stated the rectal tube was changed two or three nights before. On February 13, 2020, at 9:16 a.m., the Administrator (ADM) was interviewed. She stated there was no documentation the physician ordered Resident 1's rectal tube to be changed before it was changed on February 10, 2020. She stated the physician's order was to monitor the rectal tube and there was no physician order to change Resident 1's rectal tube on February 10, 2020. On February 13, 2020, at 9:35 a.m., Registered Nurse (RN) 1 was interviewed. RN 1 stated she spoke with the Nurse Practitioner on February 13, 2020, at 8:15 a.m., to obtain the order for the rectal tube to be changed as needed. RN 1 stated she back dated the nurse practitioner's order for February 7, 2020, when she received the order on February 13, 2020, at 8:15 a.m. On February 13, 2020, at 10:39 a.m., the DON was interviewed. The DON stated, We know it was wrong for the back dating and all of that. On February 19, 2020, at 2:15 p.m., Licensed Vocational Nurse (LVN) 1 was interviewed by telephone. LVN 1 stated she reinserted Resident 1's rectal tube on February 10, 2020, at 6:31 a.m. The facility policy titled, Rectal Tube with Connected [MEDICATION NAME] Bag, revised October 2010, was reviewed. The policy indicated, .Verify that there is a physician's order for this procedure .
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on interview and record review, the facility failed to ensure the nursing staff had developed competency prior to reinserting a rectal tube, for one of three residents (Resident 1). This failure had the potential for Resident 1 to incur complications related to the improper insertion of a rectal tube. Findings: On February 13, 2020, at 8:14 a.m., an unannounced visit was conducted to investigate a facility reported incident. On February 13, 2020, at 8:16 a.m., the Director of Nursing (DON) was interviewed. She stated Resident 1's rectal tube was reinserted at the facility on February 10, 2020 by Licensed Vocational Nurse (LVN) 1. On February 13, 2020, at 10:39 a.m., the DON was interviewed. The DON stated an inservice for rectal tube insertion was conducted on February 12, 2020 (two days after Resident 1's rectal tube was reinserted). On June 24, 2020, at 9:43 a.m., the DON was interviewed. The DON stated LVN 1 should have been inserviced on the proper rectal tube insertion procedure prior to the reinserting Resident 1's rectal tube on February 10, 2020. On June 25, 2020, at 7:46 a.m., LVN 1 was interviewed by telephone. LVN 1 stated she had not performed a rectal tube insertion before February 10, 2020. LVN 1 stated she did not receive training on the insertion of a rectal tube before she reinserted Resident 1's rectal tube on February 10, 2020. The document titled, Skin and Wound Product Information Sheet Flexi-Seal Protect Fecal Collection Device: Internal, dated March 2019, was reviewed. The document indicated, .Use with caution with clients .rectal pain, abdominal distension/pain; remove device immediately and notify Physician .
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 accurate documentation in the medical record, for one of three residents (Resident 1). This failure resulted in inaccurate documentation on Resident 1's medical record and had the potential to affect the provision of care and treatment to Resident 1. Findings: On February 13, 2020, at 8:14 a.m., an unannounced visit was conducted to investigate a facility reported incident. On February 13, 2020, at 9:16 a.m., the Administrator (ADM) was interviewed. She stated there was no documentation the physician ordered Resident 1's rectal tube to be changed before it was changed on February 10, 2020. She stated the physician's order was to monitor the rectal tube and there was no physician order to change Resident 1's rectal tube on February 10, 2020. On February 13, 2020, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Order Summary Report, dated February 7, 2020, indicated, .Rectal Tube (a plastic tube connected to a bedside drainage bag for collection of stool) - Monitor for any s/s (signs and symptoms) of infection and tube care every shift for Wound Management . The history and physical examination [REDACTED]. The Progress Notes, dated February 12, 2020, at 7:49 a.m., indicated, .tx (treatment nurse) and cna (certified nursing assistant) slowly repositioned pt (patient) at which time pt stated, Watch out for my rectal tube, it hurts its been hurting since they changed it not last night but the night before . The untitled document, dated February 13, 2020, at 8:28 a.m., indicated, Rectal tube in place for wound management. Change PRN (as needed) if tube is dislodged or not draining. There was no documented evidence the physician ordered Resident 1's rectal tube to be changed prior to February 12, 2020. There was no documented evidence of Resident 1's rectal tube reinsertion on February 10, 2020. On February 13, 2020, at 9:35 a.m., Registered Nurse (RN) 1 was interviewed. RN 1 stated she spoke with the Nurse Practitioner on February 13, 2020, at 8:15 a.m., to obtain the order for Resident 1's rectal tube to be changed as needed. RN 1 stated she back dated the Nurse Practitioner's order for February 7, 2020, when she received the order on February 13, 2020, at 8:15 a.m. On February 13, 2020, at 10:39 a.m., the Director of Nursing (DON) was interviewed. The DON

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) stated, We know it was wrong for the back dating and all of that. On February 13, 2020, at 12:16 p.m., the DON was interviewed. The DON stated Licensed Vocational Nurse (LVN) 1 did not document the rectal tube reinsertion for Resident 1 on February 10, 2020. On February 19, 2020, at 2:15 p.m., LVN 1 was interviewed by telephone. LVN 1 stated she did not document Resident 1's rectal tube reinsertion on February 10, 2020. The facility policy titled, Medication and Treatment Orders, revised July 2016, was reviewed. The policy indicated, .Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order .