STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056117	A. BUILDING _____ B. WING _____	**04/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE ROWLAND	**330 W. ROWLAND STREET COVINA, CA 91723**

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 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 comprehensive person-centered care plan for one of three sampled residents (Resident 1) to address: 1. activity needs based on the Resident Activity Assessment 2. individualized interventions to address activities of daily living (ADL) based on resident's functional ability, as indicated on the minimum data set (MDS, standardized assessment and care screening tool) This failure had the potential for the resident not to receive interventions to address specific needs, which can result to a decline in the residents' physical and emotional well-being and affect quality of life. Findings: A review of the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. which makes breathing difficult). A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 10/23/19, indicated Resident 1 was independent with cognitive skills for daily decision-making. The MDS indicated activity preferences that were very important to Resident 1 included to keep up with the news, go outside to get fresh air when the weather is good, and to do her favorite activities. It also indicated activity preferences somewhat important to Resident 1 were to listen to music, be around animals such as pets, do things with group of people and participate in religious services or practices. Resident 1 required extensive assistance with bed mobility, transfer, walking, locomotion, dressing, and eating. Resident 1 was totally dependent on staff for toilet use and personal hygiene. Resident 1 received scheduled and as needed (PRN) pain medications. Resident 1 also received non-medication intervention for pain. A review of Resident 1's physician order, dated 10/16/19, indicated may participate in activity as tolerated as not in conflict with treatment plan. A review of Resident 1's care plan titled, ADL Rehabilitation, dated 10/17/19, addressing ADLs indicated staff interventions included were to assist in ambulation as needed, provide help or assistance as needed, provide total physical assistance in ADL, Physical/Occupational therapy evaluation and treatment, and Restorative Nursing Assistant (RNA) for range of motion (ROM) and ambulation as ordered. There was no care plan developed to address activity needs. On 3/4/20 at 3:49 p.m., during a concurrent record review and interview with the MDS Coordinator, she stated some of the care plan interventions addressing Resident 1's ADLs were not accurate and should have been updated after the MDS was completed. MDS Coordinator stated the interventions indicating Resident 1 on RNA for ROM and ambulation as ordered was not accurate. The MDS Coordinator also stated based on the MDS, Resident 1 required extensive assistance in getting in and out of bed and ambulation. The MDS Coordinator stated this should have been indicated on the care plan. The MDS Coordinator stated ADL care plan should have been revised so it was specific to Resident 1's needs. On 3/4/20 at 4:31 p.m., during a concurrent record review and interview with the Director of Nursing (DON), she stated Resident 1's care plan should be specific to the resident or person centered. DON acknowledged ADL care plan interventions were not accurate. On 3/5/20 at 8:29 a.m., during an interview with the Activity Director (AD), she stated she is responsible in completing the Resident Activity Assessment, but not the care plan to address activity needs. AD stated Nursing staff completes it. On 3/5/20 at 2:03 p.m., during a concurrent record review and interview with the DON, she stated Resident 1 did not have a care plan for activity. DON stated a care plan to address activity needs based on the resident's activity preferences should have been developed. A review of the facility's policy and procedure titled, Care Planning - Interdisciplinary Team, revised 12/2008, indicated a comprehensive care plan for each resident is developed within seven (7) days of completion of the MDS. It also indicated the care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team, which includes, but is not necessarily limited to the following personnel: a) Registered Nurse who has the responsibility for the resident d) The Activity Director/Coordinator . h) Others as appropriate or necessary to meet the needs of the resident. A review of the facility's policy and procedure titled, Documentation, Activities, revised 12/2009, indicated the following records, at a minimum, are maintained by Activity Department personnel: e. Individualized Activities Care Plan or activities portion of the Comprehensive Care Plan.
F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have a documented evidence of an ongoing program to support resident's activity preferences as indicated on the activity assessment for one of three sampled residents (Resident 1). This deficient practice had the potential not to meet the resident's interests and activity needs, which could affect the physical, mental, and psychosocial well-being of the resident. Findings: A review of the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. which makes breathing difficult). A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 10/23/19, indicated Resident 1 was independent with cognitive skills for daily decision-making. The MDS indicated activity preferences that were very important to Resident 1 included to keep up with the news, go outside to get fresh air when the weather is good, and to do her favorite activities. It also indicated activity preferences somewhat important to Resident 1 were to listen to music, be around animals such as pets, do things with group of people and participate in religious services or practices. Resident 1 required extensive assistance with bed mobility, transfer, walking, locomotion, dressing, and eating. Resident was totally dependent on the staff for toilet use and personal hygiene. A review of Resident 1's physician order, dated 10/16/19, indicated may participate in activity as tolerated as not in conflict with treatment plan. A review of a facility form titled, Resident Activity Assessment, dated 10/17/19, indicated Resident 1's current activity involvement included exercise, music, parties/social events, grooming, walking/wheeling outdoors, watching television, movies, gardening/plants, talking/conversing, and Sudoku (a puzzle in which players insert the numbers one to nine into a grid consisting of nine squares). On 3/5/20 at 8:27 a.m., during a concurrent record review and interview with the Activity Director (AD), she stated the activity involvement on the Resident Activity Assessment form indicated the resident's current activity preferences. AD stated the Room Visit Record form indicated the dates when resident was provided with activities, which the resident had participated in. On 3/5/20 at 8:29 a.m., during a concurrent record review and interview with the Activity Director (AD), she stated Resident 1's Room Visit Record form, dated 10/16/19 to 11/12/19, showed blank boxes on multiple dates. AD stated there were no activities provided on the dates that had blank boxes. There were 18 out of 28 days when Resident 1 was not provided activity. AD stated it was important to provide daily activities to Resident 1 because it would help the resident to get going. AD added Resident 1 and all the other residents should be encouraged to do the activities they like and were capable of doing to prevent decline. AD stated activities should be provided by nursing and activity staff to meet resident's emotional needs. A review of the facility's policy and procedure (P&P) titled, Activities and Social Service, revised 12/2010, indicated when the Care Planning Team develops the resident's activity and social care plans, the resident will be given an opportunity to choose when, where, and how he or she will participate in activities

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

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F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and social events. It also indicated that as much as possible, the facility will provide activities, social events, and schedules compatible with the resident's interests, physical and mental assessment, and overall plan of care. The P&P also stipulated activities will be scheduled periodically during the day, as well as during evenings, weekends, and holidays.
F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a documented evidence that the side effects or adverse consequences (unpleasant symptoms, such as impairment or decline in a resident's mental/physical condition or functional /psychosocial status due to or associated with the medication) for the use of [MEDICATION NAME] ([MEDICATION NAME]-[MEDICATION NAME], medication used to relieve moderate to severe pain) was monitored for two of two sampled residents (Resident 1 and Resident 2), as indicated on the facility policy. This deficient practice had the potential to result in the use of unnecessary pain medication or/and significant adverse consequences, which can result in injury or harm to the resident. Findings: a. A review of the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]., which makes breathing difficult). A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 10/23/19, indicated Resident 1 was independent with cognitive skills for daily decision-making. Resident 1 required extensive assistance with bed mobility, transfer, walking, locomotion, dressing, and eating. Resident 1 was totally dependent on the staff for toilet use and personal hygiene. Resident 1 received scheduled and as needed (PRN) pain medications. Resident 1 also received non-medication intervention for pain. A review of Resident 1's physician's orders [REDACTED]. [MEDICATION NAME] tablet 5-325 mg one tablet by mouth one time per day at 8 a.m. for pain 2. [MEDICATION NAME] tablet 5-325 mg one tablet by mouth every six hours as needed (PRN) for severe pain (7-10/10) On 3/17/20 at 2:40 p.m., during an interview with Licensed Vocational Nurse 2 (LVN 2), she stated Resident 1 received [MEDICATION NAME] for pain during her stay at the facility. LVN 2 stated prior to giving [MEDICATION NAME], the licensed nurse needs to assess the resident for level and location of pain. LVN 2 stated pain should also be assessed after an hour to know if medication was effective. LVN 2 also stated Licensed Nurse needs to monitor the resident for the side effects of [MEDICATION NAME], such as sleepiness or drowsiness. LVN 2 stated this should be documented on the electronic medication administration record (EMAR). LVN 2 stated monitoring the side effects of [MEDICATION NAME] was important so the physician could be notified to reevaluate the use of pain medication if the resident showed any side effects. A review of the EMAR and progress notes, dated 10/16/19 to 11/12/19, indicated Resident 1 received [MEDICATION NAME] routinely and two to three times daily as PRN for pain. EMAR and progress notes did not indicate any documented evidence that the side effects/ adverse consequences for the use of [MEDICATION NAME] were monitored. On 3/17/20 at 2:47 p.m., during an interview, the Director of Nursing (DON) stated there was no documentation that the licensed nurses were monitoring the side effects of [MEDICATION NAME]. The DON stated the Licensed Nurses should click on the free text in the EMAR to document the monitoring of the side effects of [MEDICATION NAME]. DON stated this was important to ensure resident was monitored for the side effects of [MEDICATION NAME], such as dizziness and change in level of consciousness, which may result in injury or fall. A review of Resident 1's care plan titled, Pain, dated 10/17/19, indicated staff interventions included were to assess pain every shift, provide [MEDICATION NAME] daily and PRN for discomfort, repositioning and comfort care, reassess within an hour for effectiveness, and notify physician if pain was not relieved. A review of the facility's policy and procedure titled, Administering Pain Medications, revised 10/2010, indicated to conduct an abbreviated pain assessment if there has been no change of condition since the previous assessment. The assessment shall consist of at least the following components: e) evidence or reports of adverse consequences related to medications. It also indicated to document the following in the resident's medical record: 1) results of the pain assessment . 5) results of the medication (adverse or desired). According to https://www.drugs.com/cdi/[MEDICATION NAME].html, [MEDICATION NAME] has the potential for addiction, abuse, and misuse, which can lead to overdose and death. Serious, life-threatening, or fatal respiratory depression may occur. Monitor closely, especially upon initiation or following a dose increase. Along with its needed effects, [MEDICATION NAME] / [MEDICATION NAME] may cause some unwanted effects. Although not all of these side effects may occur, if they do occur they may need medical attention. Side effects that are more common included dizziness and lightheadedness. b. A review of the Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/27/20, indicated Resident 2 was independent with cognitive skills for daily decision-making. Resident 2 required supervision with bed mobility. Resident 2 required limited assistance with transfer, walking, and toilet use. Resident 2 required extensive assistance with dressing and personal hygiene. Resident 2 received scheduled and as needed (PRN) pain medications. Resident 2 also received non-medication intervention for pain. A review of Resident 2's physician's orders [REDACTED]. On 3/17/20 at 2:40 p.m., during an interview with Licensed Vocational Nurse 2 (LVN 2), she stated prior to giving [MEDICATION NAME], the licensed nurse needs to assess the resident for level and location of pain. LVN 2 stated pain should also be assessed after an hour to know if medication was effective. LVN 2 also stated Licensed Nurse needs to monitor the resident for the side effects of [MEDICATION NAME], such as sleepiness or drowsiness. LVN 2 stated this should be documented on the electronic medication administration record (EMAR). LVN 2 stated monitoring the side effects of [MEDICATION NAME] was important so the physician could be notified to reevaluate the use of pain medication if the resident showed any side effects. A review of the EMAR and progress notes, dated 3/4/20 and 3/5/20, indicated Resident 2 received [MEDICATION NAME] two times as PRN for pain. EMAR and progress notes did not indicate any documented evidence that the side effects/ adverse consequences for the use of [MEDICATION NAME] were monitored. On 3/17/20 at 2:47 p.m., during interview, the Director of Nursing (DON) stated there was no documentation that the licensed nurses were monitoring the side effects of [MEDICATION NAME]. The DON stated the Licensed Nurses should click on the free text in the EMAR to document the monitoring of the side effects of [MEDICATION NAME]. DON stated this was important to ensure resident was monitored for the side effects of [MEDICATION NAME], such as dizziness and change in level of consciousness, which may result in injury or fall. A review of Resident 2's care plan titled, Pain, dated 2/20/20, indicated staff interventions included were to assess pain occurrence, location, intensity and frequency, medicate as ordered, reassess within an hour for effectiveness, and notify physician if pain was not relieved. A review of the facility's policy and procedure titled, Administering Pain Medications, revised 10/2010, indicated to conduct an abbreviated pain assessment if there has been no change of condition since the previous assessment. The assessment shall consist of at least the following components: e) evidence or reports of adverse consequences related to medications. It also indicated to document the following in the resident's medical record: 1) results of the pain assessment . 5) results of the medication (adverse or desired). According to https://www.drugs.com/cdi/[MEDICATION NAME].html, [MEDICATION NAME] has the potential for addiction, abuse, and misuse, which can lead to overdose and death. Serious, life-threatening, or fatal respiratory depression may occur. Monitor closely, especially upon initiation or following a dose increase. Along with its needed effects, [MEDICATION NAME] / [MEDICATION NAME] may cause some unwanted effects. Although not all of these side effects may occur, if they do occur they may need medical attention. Side effects that are more common included dizziness and lightheadedness.