STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056444	A. BUILDING _____ B. WING _____	**09/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COMMUNITY EXTENDED CARE HOSPITAL OF MONTCLAIR	**9620 FREMONT AVENUE MONTCLAIR, CA 91763**

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 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** Based on interview and record review, the facility failed to ensure Respiratory Therapist (RT 1) provided accurate and complete documentation, for one of three sampled residents (Resident 1), when RT 1 and RT 2 changed Resident 1's [MEDICAL CONDITION] (placed into the hole to keep it open for breathing. The term for the surgical procedure to create this opening is tracheotomy.) on [DATE]. This failure had the potential to cause inconsistent care coordination and unmet care needs for Resident 1. Findings: During a review of Resident 1's closed clinical record, the face sheet indicated Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. (occurs when an artery to the brain is blocked). Further review indicated Resident 1 expired at the facility on [DATE]. During a review of Resident 1's Respiratory Care physician's orders [REDACTED].Change [MEDICAL CONDITION] every month to prevent tissue granulation and infection and prn (as needed) dislodgement or malfunctioning . During an interview with the Respiratory Therapist (RT 1), on [DATE], at 1:00 PM, RT 1 stated he assisted RT 2 in changing Resident 1's [MEDICAL CONDITION] on [DATE] at around 9:30 AM to 10 AM, because it was dislodged. During a review of Resident 1's Respiratory Progress Notes, documented by Respiratory Therapist (RT 1), dated [DATE] at around 12:00 PM to 12:30 PM, indicated Assisted RT (RT 2) with [MEDICAL CONDITION] change due to dislodgement. Following [MEDICAL CONDITION] change, patient saturation below 92. With manual resuscitator (used to fill in the lungs with air in a person who is unconscious and not breathing), pt (Resident 1) then ventilated and [MEDICATION NAME] with 100% FiO2 (Fraction of inspired oxygen or FiO2- volumetric fraction of oxygen in the inhaled gas. Medical patients experiencing difficulty breathing are provided with oxygen-[MEDICATION NAME] air). Patient SP02 (an estimate of the amount of oxygen in the blood) decreased below 88%, assessed for pt's pulse, pulse was not found, CPR (Cardiopulmonary resuscitation- emergency procedure that combines chest compressions often with artificial ventilation in an effort restore spontaneous blood circulation and breathing in a person who is in [MEDICAL CONDITION]) started. 911 called. EMS (Emergency Medical Services) arrived and continued CPR. MD (Medical Doctor) notified by EMS, pt declared expired. During a follow up telephone interview with RT 1, on [DATE], at 3:20 PM, RT 1 stated he should have been more detailed with his documentation for Resident 1. He stated I guess it was my fault cause (because) it appeared that it happened immediately. But I wrote that to enforce that we immediately addressed (his condition) when we saw that he was having a change in condition. During a telephone interview with the Director of Nursing (DON), on [DATE], at 10:47 AM, the DON reviewed an undated facility document titled Respiratory Care Practitioner Job Description, and stated it was not followed by the RT. She stated there was lack of documentation from the RT. The DON further stated RT are expected to document timely and accurately. During a review of an undated facility document titled Respiratory Care Practitioner Job Description indicated Assures completeness of therapy notes on a prompt basis and in an accurate manner. During a review of a facility policy and procedure titled Documentation Principles revised February 2018, indicated It is the policy of the facility that resident's clinical records shall be current and kept in detail consistent with good medical and professional practice based on the care provided to each resident .Entries must be accurate, timely, objective, specific, concise, legible, clear and descriptive.

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.