STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055409	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COMMUNITY CARE AND REHABILITATION CENTER	**4070 JURUPA AVENUE RIVERSIDE, CA 92506**

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 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed, for one of three sampled residents (Resident A), to promptly resolve the resident's grievance filed against a certified nursing assistant (CNA), when Resident A requested not to be assigned to CNA 1 due to previous conflicts with the provision of care. This failure resulted in Resident A feeling frustrated and uncomfortable with the continued assignment and care received from CNA 1. Findings: On June 23, 2020, at 8:51 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to resident right concerns. On June 23, 2020, at 9:16 a.m., Resident A was interviewed and stated that on June 6, 2020, she complained to multiple facility staff regarding how CNA 1 treated her during shower. Resident A requested not to be assigned under CNA 1's care but that the assignment continued on June 7 and 8, 2020, in spite of her complaints. She stated she filed an official grievance to social services regarding her concerns on June 9, 2020, but felt it was not addressed since CNA 1 was again assigned to her on June 18, 2020. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The annual history and physical, dated February 19, 2020, indicated Resident A had the capacity to understand and make decisions. The facility's staffing schedules and assignments were reviewed and indicated Resident A was under the care of CNA 1 on June 6, 7, 8, 2020. The grievance report filed by Resident A on June 9, 2020 was reviewed and indicated her concern about CNA 1. The form report indicated, .Resident has asked DSD (Director of Staff Development) not to give her this CNA (name of CNA) however continues to have her. The follow-up action in the form indicated the resident was assured that CNA 1 would not be assigned to her. The form did not indicate that the grievance was resolved as the response section from the complainant was left unfilled. The facility's staffing schedule and assignment, dated June 18, 2020, indicated Resident A was again under the care of CNA 1. On June 23, 2020, at 11:15 a.m., the Social Services Designee (SSD) was interviewed regarding Resident A and confirmed the resident filed a grievance on June 9, 2020, related to CNA 1's care of the resident. She stated she gave the grievance form to the DSD. She stated she failed to follow-up with the resident to see if the grievance was resolved. In a concurrent review of the grievance form, the SSD confirmed there was no documentation of a follow-up with the resident if the grievance was resolved or not. The complainant's response section was left blank/unfilled. When asked about the facility's process on grievances, she stated the facility's interdisciplinary team (IDT) would promptly address and attempt to resolve the grievance within 5 days. The facility's policy and procedure titled, Grievances/Complaint Procedure, dated June 2008, indicated: .Any resident .may file a grievance or complaint alleging discrimination in treatment, medical care, and behavior of other residents or staff members, without fear of threat or reprisal in any form. .Grievances and/or complaints may be submitted orally (spoken) or in writing and anonymously . .The facility Administrator has designated the facility's Social Service Designee (SSD) as the Grievance Official, who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion . .Upon receipt of a written grievance and/or complaint, the Department Manager will investigate the allegations and submit a written report of such findings to the SSD within 5 working days of receiving the grievance and/or complaint. .The resident, or person filing the grievance and/or complaint .will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the administrator and or SSD, or his or her designee, within 10 working days of the filing of the grievance or complaint with the facility. A written summary report will also be provided to the resident .by SSD and or Administrator and a copy will be filed in the Social Services office .
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, for one of three sampled residents (Resident A), the indwelling catheter (Foley catheter- a thin flexible tube, placed into the bladder to drain urine) was changed in a timely manner when the resident complained that it was clogged. This failure resulted in the resident's discomfort and the risk of the development of autonomic dysreflexia (a potentially life-threatening medical emergency that affects people with spinal cord injuries) due to a distended bladder. Findings: On June 23, 2020, at 8:51 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to quality of care concerns. On June 23, 2020, at 9:16 a.m., Resident A was interviewed and stated she had a history of [REDACTED]. She stated on June 6, 2020, at around 9 a.m., she informed multiple staff that she was experiencing abdominal and bladder spasms. She was concerned of a kinked or clogged Foley catheter and requested a catheter change. She stated she told multiple staff at different times and it took almost five hours until one of the staff eventually changed her catheter. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The annual history and physical, dated February 19, 2020, indicated Resident A had the capacity to understand and make decisions. A physician's orders [REDACTED]. On July 28, 2020, at 2:14 p.m., Licensed Vocational Nurse (LVN) 1 was interviewed regarding Resident A. She acknowledged Resident A requested a catheter change on June 6, 2020, at around 8 to 9 a.m. She stated she paged the treatment nurse to the room and was informed by Certified Nursing Assistant (CNA) 2 that the treatment nurse was made aware about the resident's request. She stated during her medication pass at noon time, she found out the resident's catheter was still not changed. She informed the treatment nurse about it and the catheter was eventually replaced. On July 28, 2020, at 3:05 p.m., CNA 2 was interviewed regarding Resident A and stated on June 6, 2020 since 9 a.m. until noon she had been telling multiple licensed nurses about the resident's request for a catheter change due to discomfort. She stated the treatment nurses were made aware, but nobody came. She stated the resident was having spasms, causing her discomfort, and had to wait for several hours until a licensed nurse finally changed her Foley catheter. She stated she repeatedly told several licensed nurses, including the treatment nurses, but they never addressed the patient's complaints until few hours later. She further stated the resident was upset for the long wait. On August 3, 2020, at 11:00 a.m., the Director of Nursing (DON) was interviewed regarding facility practices on indwelling catheter. She stated if a resident would complain of issues with his/her catheter, the licensed staff should listen to the complaint and assess the resident. If there is a need to change it and with a physician's orders [REDACTED]. From the International Journal of Emergency Medicine, in its article titled, Autonomic dysreflexia in a tetraplegic patient due to a blocked urethral catheter: spinal cord injury patients with [MEDICAL CONDITION] above T-6 (sixth [MEDICATION NAME] vertebrae, located just below the level of the shoulder blades), require prompt treatment of [REDACTED].Spinal cord injury patients with [MEDICAL CONDITION] above the T-6 level, in whom

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the urinary catheter is blocked, may develop (sudden) headache, sweating, high blood pressure, convulsions, cardiac [MEDICAL CONDITION], and intracranial bleed because of autonomic dysreflexia caused by a distended bladder . We report a cervical spinal cord injury patient who presented with blockage of a urinary catheter. This patient developed (generalized) convulsions because of autonomic dysreflexia, which was caused by a distended urinary bladder . Autonomic dysreflexia is a potentially life-threatening episodic hypertension that develops in 50-90% of people with tetraplegia or high [MEDICAL CONDITION] (paralysis of the legs and lower body). Autonomic dysreflexia occurs after spinal cord injury at or above the sixth [MEDICATION NAME] spinal segment, because injury at this level leaves the sympathetic control of the extensive abdominal circulation amenable to unrestrained spinal reflexes . Education of the patient, carers and family members regarding autonomic dysreflexia is vital in order to pre-vent autonomic dysreflexia and to recognize its occurrence without delay . .Spinal cord injury patients with a lesion above T-6, who develop retention of urine because of a blocked catheter, may look apparently well, but these patients can suddenly develop life-threatening autonomic dysreflexia manifested by pounding headache, high blood pressure, cardiac [MEDICAL CONDITION] (abnormal heart rhythm), convulsions, intra-cranial bleed, and acute [MEDICAL CONDITIONS] [MEDICAL CONDITION] (fluid in the lungs) .