STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056485	A. BUILDING _____ B. WING _____	05/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARLINGTON GARDENS CARE CENTER	3688 NYE AVENUE RIVERSIDE, CA 92505

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, for one of three sampled residents (Resident A), the resident received necessary care and services to promote the resident's highest practicable physical well-being, when facility staff failed to conduct a comprehensive assessment and inform the attending physician or practitioner in a timely manner of the change in the resident's condition (COC). This failure resulted in the resident's transfer and re-admission to the acute care hospital due to elevated white blood cell count (leukocytosis- white cells above the normal range in the blood, frequently a sign of an [MEDICAL CONDITION] response or infection),[MEDICAL CONDITION] (life-threatening illness caused by the body's response to an infection), and [MEDICAL CONDITION] embolism (a condition in which a blood vessel in the lungs gets blocked by a blood clot). Findings: On March 2, 2020, at 2 p.m., Resident A's Responsible Party (RP) was interviewed and stated the resident was admitted to the facility for rehabilitation due to a broken hip status [REDACTED]. She stated the nurses were notified about the change in the resident's condition, and family members were repeatedly told by staff that the physician would come in to the facility on Monday (February 10, 2020), to assess the resident. She stated during the evening of February 9, 2020, the resident had labored breathing and staff was called in to the room. She stated the staff had told her, She (Resident A) was just tired. She stated the next day, Monday, February 10, 2020, prior to the physician's visit, the family members had been requesting staff to call 911 so the resident could be evaluated in the hospital. The resident was finally seen by the physician that same day and ordered for the transfer of the resident to the hospital. She further stated the resident was admitted to the general acute care hospital (GACH) due to severe infection. On March 3, 2020, at 8:40 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to quality of care concerns. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The history and physical, dated February 5, 2020, indicated the resident had the capacity to understand and make decisions. The progress notes indicated the following: - February 4, 2020, at 11:23 p.m., .(Resident A) arrived at 2100 (9 p.m.) via gurney accompanied by two attendants and daughter at bedside . Alert and oriented X 4 (time, person, place, and situation), able to verbalize all needs .incision to right hip with dressing noted. Respirations even and unlabored . - February 5, 2020, at 10:40 a.m., Body assessment complete. Current findings .10 staples to (R) (right) upper hip . surgical non removable dressing to mid lateral (R) thigh . surgical non removable dressing to lower lateral (R) thigh . Dressing to surgical site to (R) upper hip saturated. Changed dressing per np (nurse practitioner) . - February 6, 2020, at 5:52 p.m., .AoX4 (alert and oriented X 4), verbally responsive . The laboratory results, dated February 6, 2020, indicated the following: - hemoglobin of 6.8 (normal reference range: 11.0 to 18.0); - white blood cell count (WBC- laboratory test to determine infection): 9.20 (normal reference range: 4.0-11.0) The physician's orders [REDACTED]. - CBC (complete blood count- blood test used to evaluate a person's overall health and detect a wide range of disorders), BMP (basic metabolic panel- blood test that measures the levels of electrolytes in the body and kidney function) 2/10 (February 10, 2020) . There was no documentation of an assessment of the resident's status or condition in the progress notes to address the RP's concerns of changes in the resident's condition on the weekend of February 8, 2020 (Saturday) and February 9, 2020 (Sunday). There was also no documentation in the progress notes that the physician or the practitioner was updated or informed of the concerns brought up by Resident A's family members, regarding the resident's episodes of confusion, [MEDICAL CONDITION], and shortness of breath. The physician's progress notes, dated February 10, 2020 (Monday), indicated, .pt (patient) noted to be more drowsy, fatigued, and SOB (shortness of breath) over last 3 days per dtr (daughter) . + (positive for) labored breathing, lethargic (symptom of being sleepy and sluggish) .large serosanguineous (discharge containing blood and the liquid part of blood) saturating bulky dressing on (R) hip . repeat CBC done today but results not back .will send to hospital . The nurses' progress notes, dated February 10, 2020, indicated the following: - at 11:40 a.m., .alert and oriented X 2 .feeling lethargic .(name of physician) made aware, orders to be sent out to (name of GACH) for possible [MEDICAL CONDITION] and abnormal labs (laboratory results) .family at bedside . - at 1:41 p.m., .patient placed on 3 liters of [MED]gen (with) saturation at 98%. (Name of emergency transport) arrived at 11:18 a.m., patient transported to (name of GACH) per MD request . Resident A's GACH record, dated February 10, 2020, at 4:35 p.m., indicated, .History of present illness .Her SOB (shortness of breath) has worsened in the past 3 days . reports continuous drainage from the surgical site and pain with movement of the right lower extremity . friend at bedside reports patient's mental status is not normal and sometimes is not making sense . Labs significant for leukocytosis at 35.8 (WBC) .hgb (hemoglobin) of 8.3 . lactic acid (laboratory test to determine severe infection or dehydration) 5.0 (reference range: 0.90-1.70 millimole per liter) .CTA-chest/abdomen (CT scan- combination of X-rays and a computer to create pictures of organs, bones, and other tissues) done in the ED (emergency department) significant for [MEDICAL CONDITION] emboli (blood clots, air bubbles, or piece of fatty deposits in the lungs) .in addition to a possible infectious process . On March 18, 2020, at 4:26 p.m., the Director of Nursing (DON) was interviewed regarding the COC process and stated the physician is notified of any change in the resident's condition, and the monitoring and interventions provided will be documented in the clinical record. The facility's policy and procedure titled, Change in a Resident's Condition or Status, revised May 2017, was reviewed and indicated, .The nurse will notify the resident's Attending Physician or physician on call when there has been a .significant change in the resident's .condition .
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the laboratory services were provided in a timely manner, as ordered by the practitioner, for one of three sampled residents (Resident A), when the stool occult test (a laboratory test used to check stool samples for hidden blood) for Resident A was completed three days later from the ordered test date. The failure of timely completion of ordered laboratory tests could potentially result in delayed assessments and/or delayed identification of a resident's medical problems. Findings: On March 3, 2020, at 8:40 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to quality of care concerns. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The history and physical, dated February 5, 2020, indicated the resident had the capacity to understand and make decisions. The laboratory results, dated February 6, 2020, indicated a hemoglobin of 6.8 (normal reference range: 11.0 to 18.0; an acute or chronic blood loss may indicate a low hemoglobin). The physician's orders, dated February 7, 2020, indicated the following: - Iron (medication supplement for [MEDICAL CONDITION]) 325 mg (milligrams) TID (three times a day) with meals . - CBC (complete blood count- blood test used to evaluate a person's overall health and detect a wide range of disorders) .(on) 2/10 (February 10, 2020) . - Stool OB (occult blood) X 1 . The resident's Vitals Report record indicated she had bowel movements

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

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F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) on the following dates and times: - February 7, 2020, at 7:22 p.m., small stool; - February 8, 2020, at 3:33 a.m., small stool; - February 8, 2020, at 2:21 p.m., large stool; - February 8, 2020, at 5:13 p.m., large stool; - February 9, 2020, at 12:57 p.m., large stool. The record indicated the laboratory order was processed and completed on February 10, 2020 (3 days later from the ordered date). There was no documentation in the resident's clinical record of the reason for the delay of the completion of the laboratory test when the resident had recorded bowel movements since February 7, 2020. On March 5, 2020, at 10:50 a.m., the Director of Nursing (DON) was interviewed regarding the process of carrying out laboratory orders. He stated the laboratory tests would be completed as soon as possible upon receiving orders from the practitioner. He confirmed the resident's stool was not collected for laboratory processing until February 10, 2020. He confirmed there was no documentation in the clinical record of the reason why the stool was not collected in a timely manner. The facility's policy and procedure titled, Stool Specimen, dated October 2010, was reviewed and indicated: The purpose of this procedure is to collect a stool specimen for laboratory testing. .Verify that there is a physician's order for this procedure . Review the resident's care plan to assess for any special needs of the resident . Instruct the resident to defecate into the bedpan . Prepare the label for the specimen container. Record the resident's name, room number, and the date and time the specimen was collected . The following information should be recorded in the resident's medical record . The date and time that the specimen was collected . The name and title of the individual(s) who performed the procedure . All assessment data obtained during the procedure . How the resident tolerated the procedure . If the resident refused the procedure, the reason(s) why and the interventions taken . The signature and title of the person recording the data . Notify the supervisor if the resident refuses the procedure .