STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555297	A. BUILDING _____ B. WING _____	**10/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-HEMET	**1717 WEST STETSON AVENUE HEMET, CA 92545**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **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 physician was immediately notified of Resident A's elevated blood sugar ([MEDICAL CONDITION]) when the result was above the ordered parameter. This failure resulted in the delayed management of [MEDICAL CONDITION] which had the potential for the resident to experience symptoms of [MEDICAL CONDITION], which can include frequent urination, increased thirst, blurred vision, fatigue, and headache. Findings: On September 21, 2020, 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]. A physician's orders [REDACTED].>200 (greater than 200 mg/dl) . On August 31, 2020, at 6 p.m., Resident A had a blood sugar reading of 388 mg/dl. There was no documented evidence the physician was notified of the blood sugar result that was beyond the ordered parameter of 60 to 200 mg/dl. The blood sugar summary report, dated September 1, 2020, at 9:35 a.m., indicated a blood sugar reading of 500 mg/dl. The general progress notes, dated September 1, 2020, at 11:00 a.m., indicated, Patient('s) son also made aware that patient('s) blood sugar was 500 and MD is aware, pending orders. The general progress notes, dated September 1, 2020, at 11:08 a.m., indicated, MD called back, order obtained for [MEDICATION NAME] R (insulin- medication given thru injection used to treat elevated blood sugar levels) sliding scale (set of instructions for administering insulin dosages based on specific blood glucose readings) before meals. Order carried and noted. The general progress notes, dated September 1, 2020, at 1:16 p.m., indicated, .PT had 1 episode of asymptomatic [MEDICAL CONDITION] and was treated for [REDACTED]. (Blood sugar) checked and is 371 mg/dl. Pt just finished having lunch and tolerated 50% of meal . On September 1, 2020, at 12:18 p.m., Resident A's record was reviewed with the Unit Manager (UM) and confirmed there was no documented evidence the licensed staff notified the physician of the resident's blood sugar result of 388 mg/dl. She stated staff should have notified the physician when the resident's blood sugar was beyond the ordered parameters. The facility's policy and procedure titled, Glucose (sugar) Blood Monitoring (Finger Stick Blood Sugar), dated August 2014, was reviewed and it indicated: Purpose: To monitor blood sugar levels and to observe for complications of altered sugar levels in blood . Normal glucose for an adult is 60-110 mg/dl . Verify physician's orders [REDACTED]. Suggested Documentation . unusual observations and/or complaints and subsequent interventions including communications with physician. According to Potter, Perry, Stockert, and Hall, from the Fundamentals of Nursing, Tenth Edition, copyright 2017, it indicated: Blood Glucose Monitoring . Obtain test results . Compare glucose meter reading with normal blood glucose levels and previous test results . Unexpected Outcomes and Related Interventions: Blood glucose level is above or below target range . continue to monitor patient . Notify health care provider . Report blood glucose levels out of target and the action taken for [DIAGNOSES REDACTED] (low blood sugar level) or [MEDICAL CONDITION]. Report patient response to treatment for [REDACTED].
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) received necessary care and services consistent with professional standards of practice and the facility's policy and procedure when: a. Licensed staff failed to complete the neurological checks (neurochecks - brief neurologic assessments performed repeatedly to monitor changes in the resident's condition) after the resident's unwitnessed fall incident; This failure resulted in the lack of monitoring of the resident's condition after a fall incident and a potential for delayed necessary care and interventions; and b. The licensed staff failed to immediately address the resident's elevated blood sugar ([MEDICAL CONDITION]), document appropriate interventions provided, and promptly notify the physician when the blood sugar result was above the physician-ordered parameter. This failure resulted in the delayed management of [MEDICAL CONDITION] which had the potential for the resident to experience symptoms of [MEDICAL CONDITION], which can include frequent urination, increased thirst, blurred vision, fatigue, and headache. Findings: On September 21, 2020, 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]. a. Resident A's general acute care hospital's (GACH) history and physical notes, dated August 29, 2020, indicated, .presents to ED (emergency department) with concerns of chest wall pain that has been going on for 2 weeks. Patient states that she developed chest wall pain from several falls that she has had within the past 2 weeks. Patient reports that she fell on to a table with books .and admits to head trauma at that time. Patient reports she has a walker but does not use it . Patient reports that she falls due to her diminished vision. Patient states that 4 days after her fall she fell again but has not fallen since . The skilled nursing facility's general progress notes for Resident A, dated September 1, 2020, at 5:48 a.m., indicated, CNA (certified nursing assistant) came out of PT's (patient's) room after providing care and assisting to the bathroom, per CNA PT is inquiring if she has an appointment today, as LN (licensed nurse) was checking the PT's chart a loud crash was heard from (the) room, LN and CNA ran into (the) room, PT sitting on her bottom next to TV . LN assessed for injuries, none noted at this time, able to move all extremities . PT stated, I was just getting up to see what was going on . neuro checks started per facility protocol, d/t (due to) unwitnessed fall . A document titled, Release For Discharge Against Medical Advice, dated September 1, 2020, at 4:41 p.m., indicated the document/release form was signed by the resident's son. The general progress notes, dated September 1, 2020, at 4:49 p.m., indicated, .Pt's son insisted on taking pt AMA (against medical advice). MD (physician) was notified . The documented titled, Neurological Evaluation Flow Sheet, indicated, Directions: Complete neurological evaluation with vital signs initially, then every 30 minutes X 4, then every hour X 4, then every 8 hours X 9 (72 hours) . The document indicated an assessment from 5:45 a.m. to 6:15 a.m., on September 1, 2020, and the rest of the document sections were left blank/unfilled. On September 21, 2020, at 3:28 p.m., Resident A's record was reviewed with the Director of Nursing (DON) and confirmed the neurocheck assessment was not fully completed after the resident had an unwitnessed fall incident on September 1, 2020. In a concurrent interview with the DON regarding the facility's policy and procedure, she stated licensed staff should complete the neurocheck assessment for 72 hours after any unwitnessed fall incident in the facility. The facility's policy and procedure titled, Neurological: Neurological Evaluation, dated March 2010, was reviewed and it indicated: A neurological evaluation is used to establish a baseline neurological status upon which subsequent evaluations may be compared and changes in neurological status may be determined . After the completion of initial neurological evaluation with vital signs, continue evaluations every

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) 30-minutes X 4, then every 1-hour X 4, then every 8-hours x 9 (for the next 72-hours) . b. A physician's orders [REDACTED].>200 (greater than 200 mg/dl) . On August 31, 2020, at 6 p.m., Resident A had a blood sugar reading of 388 mg/dl. There was no documented evidence the physician was notified of the blood sugar result that was beyond the ordered parameter of 60 to 200 mg/dl. There was also no documentation of an assessment of the resident's condition or the interventions provided during the resident's hyperglycemic episode. The blood sugar summary report, dated September 1, 2020, at 9:35 a.m., indicated a blood sugar reading of 500 mg/dl. The general progress notes, dated September 1, 2020, at 11:00 a.m., indicated, Patient('s) son also made aware that patient('s) blood sugar was 500 and MD is aware, pending orders. The general progress notes, dated September 1, 2020, at 11:08 a.m., indicated, MD called back, order obtained for [MEDICATION NAME] R (insulin- medication given thru injection used to treat elevated blood sugar levels) sliding scale (set of instructions for administering insulin dosages based on specific blood glucose readings) before meals. Order carried and noted. The general progress notes, dated September 1, 2020, at 1:16 p.m., indicated, .PT had 1 episode of asymptomatic [MEDICAL CONDITION] and was treated for [REDACTED]. (Blood sugar) checked and is 371 mg/dl. Pt just finished having lunch and tolerated 50% of meal . On September 1, 2020, at 12:18 p.m., Resident A's record was reviewed with the Unit Manager (UM) and confirmed there was no documented evidence the licensed staff notified the physician of the resident's blood sugar result of 388 mg/dl. She stated staff should have notified the physician when the resident's blood sugar was beyond the ordered parameters. The facility's policy and procedure titled, Glucose (sugar) Blood Monitoring (Finger Stick Blood Sugar), dated August 2014, was reviewed and it indicated: Purpose: To monitor blood sugar levels and to observe for complications of altered sugar levels in blood . Normal glucose for an adult is 60-110 mg/dl . Verify physician's orders [REDACTED]. Suggested Documentation . unusual observations and/or complaints and subsequent interventions including communications with physician. According to Potter, Perry, Stockert, and Hall, authors of Fundamentals of Nursing, Tenth Edition, Copyright 2017, Blood Glucose Monitoring . Obtain test results . Compare glucose meter reading with normal blood glucose levels and previous test results . Unexpected Outcomes and Related Interventions: Blood glucose level is above or below target range . continue to monitor patient . Notify health care provider . Report blood glucose levels out of target and the action taken for [DIAGNOSES REDACTED] (low blood sugar level) or [MEDICAL CONDITION]. Report patient response to treatment for [REDACTED].