STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056185	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF MENIFEE	**27600 ENCANTO DRIVE SUN CITY, CA 92586**

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 -** Some	**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 and implement comprehensive person-centered care plans for four of six sampled residents (Resident A, B, C and D) in a universe of 66 residents. This failure occurred when; 1. A comprehensive care plan for Resident A, lacked documentation that indicated what the resident's impaired cognitive ability was related to; and 2. A comprehensive care plan was not developed nor implemented to address pain for the four residents with measurable objectives and timeframes set to meet the residents' needs. These failures had the potential to negatively impact the residents' quality of life. Findings: On May 28, 2020, at 11:05 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On May 28, 2020, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident A's facility record titled, History and Physical, (H&P) dated April 29, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: repeated falls, RT (right) hip pain. A review of Resident A's care plans identified a care plan with the focus, The resident has (Specify: impaired cognitive ability/impaired thought processes r/t) (related to). The focus failed to determine what the impaired cognitive ability was related to. The failure to identify the cause of the impaired cognitive ability and impaired thought process limited the implementation of detailed interventions to accurately address the resident's needs. Further review of Resident A's facility record found no care plan developed nor implemented to address the resident's right knee pain or right hip pain with measurable objectives and timeframes set to meet the resident's needs. On June 5, 2020, at 11:26 a.m., a phone interview and concurrent record review were conducted with the facility's Director of Nursing (DON). The DON was asked after reviewing Resident A's facility care plans if the resident should have had a care plan that addressed the resident's pain given that the resident had, Pain in right knee, documented as his third [DIAGNOSES REDACTED]. The DON confirmed that it would be expected that the resident would have a care plan for pain. On May 28, 2020, a review of Resident B's facility medical record was conducted. Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident B's facility record titled, History and Physical, (H&P) dated May 4, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: 89 Y F (year old female) with chronic back pain admitted with [DIAGNOSES REDACTED]. Further review of Resident B's facility record found no care plan developed nor implemented to address the resident's low back pain, or pain related to her surgery with measurable objectives and timeframes set to meet the resident's needs. On June 5, 2020, at a phone interview and concurrent record review were conducted with the facility's DON. The DON was asked after reviewing Resident B's facility care plans if the resident should have had a care plan that addressed the resident's pain given the resident was admitted to the facility after a fall and surgery to fix her femur fracture. The DON was also asked regarding the care plan to address pain for the resident given, Low back pain, was documented as her principal diagnosis. The DON confirmed that it would be expected that the resident would have a care plan for pain On May 28, 2020, a review of Resident C's facility medical record was conducted. Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident C's facility record found a care plan that indicated, Resident expresses (SPECIFY pain/discomfort) r/t (related to). There was no reason listed for the possible cause of the resident's pain. The care plan failed to identify what the pain or discomfort was caused by or related to. On June 5, 2020, a phone interview and concurrent record review were conducted with the facility's DON. The DON was asked after reviewing Resident C's facility care plans if there should have been documentation that indicated what the resident's pain or discomfort could be related to. The DON stated that this was a baseline care plan that had failed to be updated. The DON confirmed it care plan should have had more detail and interventions. On May 28, 2020, a review of Resident D's facility medical record was conducted. Resident D was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident D's facility record found no care plan developed nor implemented to address the resident's left knee pain with measurable objectives and timeframes set to meet the resident's needs. On June 5, 2020, a phone interview and concurrent record review were conducted with the facility's DON. The DON was asked after reviewing Resident D's facility care plans if the resident should have had a care plan that addressed the resident's pain. The DON stated, Yes, there should be a care plan for pain. Review of a facility policy titled, Resident Assessment Instrument & Care Plan, issued date, 06/08/2020, indicated, The Care plan includes measure objectives, timeframes to meet the patient's cultural, nursing, mental, and psychosocial needs including services being provided to meet those needs.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure professional standards of quality of care were met for four of six sampled residents (Residents A, B, C and D) in a universe of 66 residents when; 1. The facility had documented Resident A in multiple progress notes up until the date of his discharge as a Feeder, (a staff member feeds the resident meals because he/she is unable to feed themselves) when the resident was documented on his discharge as needing only supervision while eating; 2. A care plan for Resident A's failed to identify and document what the resident's impaired cognitive ability was related to; 3. A care plan for Resident C's failed to identify and document what the possible pain or discomfort was caused by or related to; 4. The facility failed to ensure that upon admission to the facility comprehensive person-centered care plans were developed and implemented for four Residents A, B, C and D related to their pain; 5. The facility failed to ensure licensed vocational nursing progress notes were documented accurately of services provided; and 6. The facility failed to ensure nursing progress notes for Residents A, C and D were not entered with identical documentation for multiple entries. This failure had the potential to place Residents A, C and D at risk for serious medical complications [REDACTED]. Findings: On May 28, 2020, at 11:05 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On May 28, 2020, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident A's facility record titled, History and Physical, (H&P) dated April 29, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: repeated falls, RT (right) hip pain. Review of Resident A's discharge, Minimum Data Set, (MDS- standardized assessment for the management of care) dated May 11, 2020, indicated the resident upon discharge required only supervision when eating. Supervision which indicated, oversight, encouragement or cueing. Review of Resident A's facility progress notes indicated that the resident had been documented by nursing staff that, Resident is a feeder. Assisted by assigned CNA. The progress notes were dated, 5/3, 5/4, 5/5, 5/7, 5/8, 5/9, and 5/10. The resident was discharged from the facility on 5/11/2020. A review of Resident A's care plans identified a care plan with the focus, The resident has (Specify: impaired cognitive ability/impaired thought processes r/t) (related to).

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) The focus failed to determine what the impaired cognitive ability was related to. The failure to identify the cause of the impaired cognitive ability and impaired thought process limited the implementation of detailed interventions to accurately address the resident's needs. Further review of Resident A's facility record found no care plan developed nor implemented to address the resident's right knee and right hip pain with measurable objectives and timeframes set to meet the resident's needs. A review of Resident A's skilled service notes indicated that his Physical Therapy (PT) services were discontinued on May 8, 2020, and that his Occupational Therapy (OT) services were discontinued on May 7, 2020. However, the resident's progress notes dated 5/8/2020, 5/9/2020, and 5/10/2020, indicated, Continue with PT/OT for rehab as ordered. Further review of Resident A's facility record identified a progress note dated, 4/29/2020, authored by LVN 2. On 5/2/2020, LVN 2 documented the same entry. The only difference was the vital signs and the last sentence of the entry. On 5/3/2020, 5/4/2020, and 5/5/2020, LVN 2 documented the same skilled note, the only difference in the three separate days entries were the vital signs. On 5/9/2020, LVN 2 entered a skilled note, on 5/10/2020, she entered the same note, the only difference between the notes were the vital signs and in this note the LVN left out, Will continue to monitor. On May 28, 2020, a review of Resident B's facility medical record was conducted. Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident B's facility record titled, History and Physical, (H&P) dated May 4, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: 89 Y F (year old female) with chronic back pain admitted with [DIAGNOSES REDACTED]. Further review of Resident B's facility record found no care plan developed nor implemented to address the resident's low back pain or pain due to surgery with measurable objectives and timeframes set to meet the resident's needs. A review of Resident B's skilled service notes indicated that her Physical Therapy (PT) services were discontinued on May 15, 2020, and that her Occupational Therapy (OT) services were also discontinued on May 15, 2020. However, the resident's progress notes dated 5/16/2020, 5/17/2020, and 5/18/2020, indicated, Continue with PT and OT as ordered. On May 28, 2020, a review of Resident C's facility medical record was conducted. Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident C's facility record found a care plan that indicated, Resident expresses (SPECIFY pain/discomfort) r/t (related to). There was no reason listed for the possible cause of the resident's pain. The care plan failed to identify what the pain or discomfort was caused by or related to. A review of Resident C's skilled service notes indicated that his Physical Therapy (PT) services were discontinued on May 8, 2020, and that his Occupational Therapy (OT) services were discontinued on May 7, 2020. However, the resident's progress notes dated 5/9/2020, 5/10/2020, 5/11/2020, and 5/12/2020, indicated, continues with skilled pt/ot services tolerated well. Further review of Resident C's facility record identified a Skilled Note, dated 5/3/2020, authored by a licensed vocational nurse (LVN 1) had been re-entered with the identical verbiage on 5/4/2020, by LVN 3. Additional review of Resident C's progress notes found multiple, Skilled Notes, with the documentation nearly identical to the previous day's entries. The only changes in the progress notes were the vital signs and the addition of a sentence at the end of the note. On May 28, 2020, a review of Resident D's facility medical record was conducted. Resident D was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident D's facility record found no care plan developed nor implemented to address the resident's left knee pain with measurable objectives and timeframes set to meet the resident's needs. A review of Resident D's skilled service notes indicated that his Physical Therapy (PT) services were discontinued on May 10, 2020, and that his Occupational Therapy (OT) services were discontinued on May 8, 2020. However, the resident's progress notes dated 5/9/2020, and 5/11/2020, indicated, On PT/OT programs. A progress note dated, 5/10/2020, indicated, PT and OT for rehab as ordered. Further review of Resident D's facility record identified a progress note dated, 4/28/2020, authored by LVN 1. On 5/1/2020, LVN 1 documented the same entry, the only difference were the vital signs. On 5/4/2020, LVN 3 documented a progress note. On 5/5/2020, 5/6/2020, 5/8/2020, 5/9/2020 and 5/11/2020, LVN 1 entered the exact same progress note except for the vital signs. On June 5, 2020, at 11:26, a phone interview and concurrent record review were conducted with the facility's Director of Nursing (DON). The DON was asked after reviewing Residents A, B, C and D care plans, if the residents should have had a care plan that addressed their pain. The DON confirmed that the residents should have had a care plan to address their pain. The DON was then asked the facility's expectation for accuracy in documentation. The DON stated that the staff are expected to document the care given to the patient and that the staff should be checking documentation and orders for the residents. The DON further stated that the documentation should be, different on a day to day basis, and is, supposed to be accurate. On June 5, 2020, at 1:07 p.m., a concurrent phone interview and record review were conducted with LVN 1. LVN 1 was asked the facility's expectation in documentation. LVN 1 stated, Normally my understanding, was that skilled notes, we will check the patient every single day. When asked about PT and OT services being documented as performed after the services had been discontinued. LVN 1 stated that the documentation, was supposed to be accurate. When asked about multiple entries made with the same documentation, LVN 1 stated that, we should make our own notes, and that they were expected to document, accurately and in detail. On June 15, 2020, at 3:30 p.m., a phone interview was conducted with LVN 2. LVN 2 was asked the facility's expectation in accurate documentation. LVN 2 stated that the facility, wants us to chart everything accurately for that day. LVN 2 continued that they were expected to document any change of condition, and to document, what we see. When asked why she had documented PT/OT services after the services had been discontinued. LVN stated that it was her mistake. The LVN continued that for the most part she tried to check the orders. A review of the Vocational Nursing Practice Act indicated, Scope of Vocational Nursing Practice: The licensed vocational nurse performs services requiring technical and manual skills which include the following: (a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan . It further indicated, .Performance Standards: (a) A licensed vocational nurse shall safeguard patients'/clients' health and safety by actions that include but are not limited to the following: .(2) Documenting patient/client care in accordance with standards of the profession .
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were accurately documented and contained a record of accurate detailed resident's assessments and comprehensive plans of care for four of six sampled residents (Residents A, B, C and D) in a universe of 66 residents when; 1. The facility failed to ensure that upon admission to the facility comprehensive person-centered care plans were developed and implemented for four residents, Residents A, B, C and D; 2. The facility failed to ensure licensed vocational nursing progress notes were documented accurately of services provided; and 3. The facility failed to ensure nursing progress notes for Residents A, C and D were not entered with identical documentation for multiple entries. Findings: On May 28, 2020, at 11:05 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On May 28, 2020, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident A's facility record titled, History and Physical, (H&P) dated April 29, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: repeated falls, RT (right) hip pain. Review of Resident A's discharge, Minimum Data Set, (MDS- standardized assessment for the management of care) dated May 11, 2020, indicated the resident upon discharge required only supervision when eating. Supervision which indicated, oversight, encouragement or cueing. Review of Resident A's facility progress notes indicated that the resident had been documented by nursing staff that, Resident is a feeder. Assisted by assigned CNA. The progress notes were dated, 5/3, 5/4, 5/5, 5/7, 5/8, 5/9, and 5/10. The resident was discharged from the facility on 5/11/2020. A review of Resident A's care plans identified a care plan with the focus, The resident has (Specify: impaired cognitive ability/impaired thought processes r/t) (related to). The focus failed to determine what the impaired cognitive ability was related to. The failure to identify the cause of the impaired cognitive ability and impaired thought process limited the implementation of detailed interventions to accurately address the resident's needs. Further review of Resident A's facility record found no care plan developed nor implemented to address the resident's right knee and right hip pain with measurable objectives and timeframes set to meet the resident's needs. A review of Resident A's skilled service notes indicated that his Physical Therapy (PT) services were discontinued on May 8, 2020, and that his Occupational Therapy (OT) services were discontinued on May 7, 2020. However, the resident's progress notes dated 5/8/2020, 5/9/2020, and 5/10/2020, indicated, Continue with PT/OT for rehab as ordered. Further review of Resident A's facility

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) record identified a progress note dated, 4/29/2020, authored by LVN 2. On 5/2/2020, LVN 2 documented the same entry. The only difference was the vital signs and the last sentence of the entry. On 5/3/2020, 5/4/2020, and 5/5/2020, LVN 2 documented the same skilled note, the only difference in the three separate days entries were the vital signs. On 5/9/2020, LVN 2 entered a skilled note, on 5/10/2020, she entered the same note, the only difference between the notes were the vital signs and in this note the LVN left out, Will continue to monitor. On May 28, 2020, a review of Resident B's facility medical record was conducted. Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident B's facility record titled, History and Physical, (H&P) dated May 4, 2020, indicated that, This resident: can make needs known but can not make medical decisions. The H&P further indicated, History: 89 Y F (year old female) with chronic back pain admitted with [DIAGNOSES REDACTED]. Further review of Resident B's facility record found no care plan developed nor implemented to address the resident's low back pain or pain due to surgery with measurable objectives and timeframes set to meet the resident's needs. A review of Resident B's skilled service notes indicated that her Physical Therapy (PT) services were discontinued on May 15, 2020, and that her Occupational Therapy (OT) services were also discontinued on May 15, 2020. However, the resident's progress notes dated 5/16/2020, 5/17/2020, and 5/18/2020, indicated, Continue with PT and OT as ordered. On May 28, 2020, a review of Resident C's facility medical record was conducted. Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident C's facility record found a care plan that indicated, Resident expresses (SPECIFY pain/discomfort) r/t (related to). There was no reason listed for the possible cause of the resident's pain. The care plan failed to identify what the pain or discomfort was caused by or related to. A review of Resident C's skilled service notes indicated that his Physical Therapy (PT) services were discontinued on May 8, 2020, and that his Occupational Therapy (OT) services were discontinued on May 7, 2020. However, the resident's progress notes dated 5/9/2020, 5/10/2020, 5/11/2020, and 5/12/2020, indicated, continues with skilled pt/ot services tolerated well. Further review of Resident C's facility record identified a Skilled Note, dated 5/3/2020, authored by a licensed vocational nurse (LVN 1) had been re-entered with the identical verbiage on 5/4/2020, by LVN 3. Additional review of Resident C's progress notes found multiple, Skilled Notes, with the documentation nearly identical to the previous day's entries. The only changes in the progress notes were the vital signs and the addition of a sentence at the end of the note. On May 28, 2020, a review of Resident D's facility medical record was conducted. Resident D was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident D's facility record found no care plan developed nor implemented to address the resident's left knee pain with measurable objectives and timeframes set to meet the resident's needs. A review of Resident D's skilled service notes indicated that his Physical Therapy (PT) services were discontinued on May 10, 2020, and that his Occupational Therapy (OT) services were discontinued on May 8, 2020. However, the resident's progress notes dated 5/9/2020, and 5/11/2020, indicated, On PT/OT programs. A progress note dated, 5/10/2020, indicated, PT and OT for rehab as ordered. Further review of Resident D's facility record identified a progress note dated, 4/28/2020, authored by LVN 1. On 5/1/2020, LVN 1 documented the same entry, the only difference were the vital signs. On 5/4/2020, LVN 3 documented a progress note. On 5/5/2020, 5/6/2020, 5/8/2020, 5/9/2020 and 5/11/2020, LVN 1 entered the exact same progress note except for the vital signs. On June 5, 2020, at 11:26, a phone interview and concurrent record review were conducted with the facility's Director of Nursing (DON). The DON was asked after reviewing Residents A, B, C and D care plans, if the residents should have had a care plan that addressed their pain. The DON confirmed that the residents should have had a care plan to address their pain. The DON was then asked the facility's expectation for accuracy in documentation. The DON stated that the staff are expected to document the care given to the patient and that the staff should be checking documentation and orders for the residents. The DON further stated that the documentation should be, different on a day to day basis, and is, supposed to be accurate. On June 5, 2020, at 1:07 p.m., a concurrent phone interview and record review were conducted with LVN 1. LVN 1 was asked the facility's expectation in documentation. LVN 1 stated, Normally my understanding, was that skilled notes, we will check the patient every single day. When asked about PT and OT services being documented as performed after the services had been discontinued. LVN 1 stated that the documentation, was supposed to be accurate. When asked about multiple entries made with the same documentation, LVN 1 stated that, we should make our own notes, and that they were expected to document, accurately and in detail. On June 15, 2020, at 3:30 p.m., a phone interview was conducted with LVN 2. LVN 2 was asked the facility's expectation in accurate documentation. LVN 2 stated that the facility, wants us to chart everything accurately for that day. LVN 2 continued that they were expected to document any change of condition, and to document, what we see. When asked why she had documented PT/OT services after the services had been discontinued. LVN stated that it was, her mistake. The LVN continued that for the, most part she tried to check the orders. Review of a facility policy titled, Documentation, long-term care, revised, November 15, 2019, indicated, Documentation is the process of preparing a complete record of a resident's care and is a vital tool for communication among health care team members. Accurate, detailed documentation shows the extent and quality of the care that nurses provide, the outcomes of that care, and the treatment and education that the resident still needs. Thorough, accurate documentation decreases the risk of miscommunication and errors and promotes continuity of care. The policy further indicated, Document the resident's vital signs, your assessment findings, the resident's care plan, your interventions, and the resident's response to your interventions .