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 _____	06/17/2020

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 a comprehensive person-centered care plan for four of six sampled residents (Residents A, B, C and D) in a universe of 66 residents. This failure occurred when a comprehensive care plan was not developed nor implemented to address pain for the residents with measurable objectives and timeframes set to meet the residents' needs. This failure 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 May 4, 2020, indicated, 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 A's facility record found no care plan developed nor implemented to address pain for the resident with measurable objectives and timeframes set to meet the resident's needs. 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 Resident A'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 and that, 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 B's facility medical record was conducted. Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident B's facility record found a care plan that indicated, Resident expresses (SPECIFY pain/discomfort) r/t (related to). There was no reason documented for the possible cause of the resident's pain. The care plan failed to identify what the pain or discomfort was 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 B'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 that the care plan should have had more detail and interventions. 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]. A review of Resident C'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. Further review of Resident C's facility record found no care plan developed nor implemented to address pain for the resident 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 C'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 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 pain for the resident 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 (sic) 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 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 that addressed the residents' pain. 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 B, C and D were not entered with identical documentation for multiple entries. This failure had the potential to place Residents B, 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 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 A's facility record found no care plan developed nor implemented to address pain for the resident with measurable objectives and timeframes set to meet the resident's needs. A review of Resident A's skilled service notes indicated that her Physical Therapy (PT) services were discontinued (stopped) 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 B's facility medical record was conducted. Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident B'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 related to. A review of Resident B'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 B's facility record identified a Skilled Note, dated 5/3/2020, authored by a licensed vocational nurse (LVN 1) that had been re-entered with identical verbiage on 5/4/2020, by LVN 3. Additional review of Resident B'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 vital signs and the addition of a sentence at the end of the note. On May 28, 2020, a review of Resident C's facility medical record was conducted. Resident

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) C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident C'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. Further review of Resident C's facility record found no care plan developed nor implemented to address pain for the resident with measurable objectives and timeframes set to meet the resident's needs. 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 5/8/2020, 5/9/2020, and 5/10/2020, indicated, Continue with PT/OT for rehab as ordered. Further review of Resident C'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 were 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 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 pain for the resident 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. Multiple attempts were made to speak with LVN 2. However, no contact was made. 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 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents received treatment and care in accordance to a comprehensive care plan, related to pain management for four of six sampled residents (Resident A, B, C and D) in a universe of 66 residents. This failure occurred when a comprehensive care plan was not developed nor implemented to address pain for the residents with measurable objectives and timeframes set to meet the residents' needs. This failure had the potential to negatively impact the physical and psychosocial well-being of the four residents. 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 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]. A review of Resident A's, Minimum Data Set, (MDS- standardized assessment for the management of care) dated May 8, 2020, indicated a BIMS, (brief interview for mental status- screening tool to assess mental capability) score of 10 out of 15 (scores 08-12 indicates moderately impaired). Further review of Resident A's facility record found no care plan developed nor implemented to address pain for the resident with measurable objectives and timeframes set to meet the resident's needs. 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 April 24, 2020, indicated that, This resident: has the capacity to understand and make decisions. The H&P further indicated, Skin: Psoriasis- some skin ulcer? A review of Resident B's, Minimum Data Set, (MDS- standardized assessment for the management of care) dated April 30, 2020, indicated a BIMS, (brief interview for mental status- screening tool to assess mental capability) score of 15 out of 15 (scores 13-15 indicates cognitively intact). Further review of Resident B'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 related to. 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]. A review of Resident C'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 C's, Minimum Data Set, (MDS- standardized assessment for the management of care) dated May 1, 2020, indicated a BIMS, (brief interview for mental status- screening tool to assess mental capability) score of 05 out of 15 (scores 13-15 indicates severe impairment). Further review of Resident C'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 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]. A review of Resident D's facility record titled, History and Physical, (H&P) dated April 29, 2020, indicated that, This resident: has the capacity to understand and make decision. 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, 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. Review of a facility policy titled, Resident Assessment Instrument & Care Plan, issued date, 06/08/2020, indicated, The Care plan includes measure (sic) objectives, timeframes to meet the patient's cultural, nursing, mental, and psychosocial needs including services being provided to meet those needs.
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 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 that addressed the residents' pain. 2. The facility failed to ensure licensed vocational nursing progress notes were documented accurately of services provided; and

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) 3. The facility failed to ensure nursing progress notes for Residents B, 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 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 A's facility record found no care plan developed nor implemented to address pain for the resident with measurable objectives and timeframes set to meet the resident's needs. A review of Resident A's skilled service notes indicated that her Physical Therapy (PT) services were discontinued (stopped) 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 B's facility medical record was conducted. Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident B'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 related to. A review of Resident B'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 B's facility record identified a Skilled Note, dated 5/3/2020, authored by a licensed vocational nurse (LVN 1) that had been re-entered with identical verbiage on 5/4/2020, by LVN 3. Additional review of Resident B'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 vital signs and the addition of a sentence at the end of the note. 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]. A review of Resident C'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. Further review of Resident C'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. 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 5/8/2020, 5/9/2020, and 5/10/2020, indicated, Continue with PT/OT for rehab as ordered. Further review of Resident C'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 were 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 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. Multiple attempts were made to speak with LVN 2. However, no contact was made. 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 .