STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055914	A. BUILDING _____ B. WING _____	**06/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLYMOUTH VILLAGE	**819 SALEM DRIVE REDLANDS, CA 92373**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 observation, interview and record review, the facility failed to: 1. Document a physician's order for standard contact isolation, 2. Complete a plan of care for standard contact isolation, For one of 3 sampled residents (Resident 3) tested positive for COVID 19. This failure resulted in incomplete documentation for Resident 3. Findings: An abbreviated survey was conducted on April 10, 2020, at 9:25 AM to investigate a complaint related to infection control. During a review of Resident 3's clinical record, the face sheet indicated an admitted [DATE] with [DIAGNOSES REDACTED].) During an observation on April 10, 2020, at 10:27 AM, Licensed Vocational Nurse (LVN 1) stood near rooms used for standard contact isolation (used for infections, diseases, or germs that are spread by touching the patient or items in the room.) LVN 1 stated, Resident 3 was tested for COVID 19 and the test result came back positive. Resident 3 was then moved into contact isolation. LVN 1 further stated that Resident 3 had been in isolation for a couple of days. During a clinical record review of Resident 3's Physicians Orders (provides directions to the staff), a Physicians Order for Contact Isolation (informs the staff of the type of isolation to be used), was not documented in Resident 3's medical records. During an interview and concurrent clinical record review for Resident 3, with LVN 2 on April 10, 2020 at 12:52 PM, LVN 2 stated, (Resident 3) should have had a Physician's Order for Contact Isolation. LVN 2 confirmed that Resident 3 did not have a Physician's Order for Contact Isolation when he tested positive for COVID 19. LVN 2 was not able to provide documentation that stated Resident 3 had a Physician's Order for Contact Isolation. During an interview with the Administrator on April 10, 2020, at 1:23 PM, Administrator stated, (Resident 3) should have had orders for Isolation. The facility's Policy and Procedure titled Charting and Documentation dated, July 2017, indicated All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record 2. The following information is to be documented in the resident medical record: c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; .3. Documentation in the medical record will be objective (not opinionated or speculative), completed, and accurate . 2. During a review of Resident 3's clinical record, the face sheet indicated an admitted [DATE] with [DIAGNOSES REDACTED].) During and observation on April 10, 2020, at 10:27 AM, Licensed Vocational Nurse (LVN 1) stood near rooms used for standard contact isolation (used for infections, diseases, or germs that are spread by touching the patient or items in the room.) LVN 1 stated, Resident 3 was tested for COVID 19 and the test result came back positive. Resident 3 was then moved into contact isolation. LVN 1 further stated that Resident 3 had been in isolation for a couple of days. During a clinical record review of Resident 3's Care plans, a plan of care (informs staff of the kind of care they are to provide) was not documented in Resident 3's medical records. During an interview and concurrent clinical record review for Resident 3, with LVN 2 on April 10, 2020, at 12:52 PM, LVN 2 stated, (Resident 3) should have had a plan of care for contact isolation. LVN 2 confirmed that Resident 3 did not have a plan of care for isolation when he tested positive for COVID 19. LVN 2 was not able to provide documentation that stated Resident 3 had a plan of care for isolation. During an interview with the Administrator on April 10, 2020 at 1:23 PM stated, (Resident 3) should have had a care plan for isolation. The facility's Policy and Procedure titled Care Plans, Comprehensive Person-Centered dated, December 2016, indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change .

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.