STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055708	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGACY POST-ACUTE REHABILITATION	**1335 N. WATERMAN AVENUE SAN BERNARDINO, CA 92404**

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 follow their policy and procedure when a staff did not document the administration of a medication for one of three sampled residents (Resident A). This failure had the potential to result in an inappropriate care for Resident A, leading to avoidable harm. Findings: An unannounced visit was conducted on (NAME)13, 2019 at 9:02 AM, to investigate a complaint regarding quality of care. During a review of physician's orders [REDACTED]. During a review of Resident A's Initial Change of Condition, dated (NAME)26, 2019 at 06:37 AM, the Nurse Notes on the report indicated .at 12:30, BS (blood sugar) was checked and was 38, went up to 130 During a review of the Medication Administration for Resident A, dated (NAME)26, 2019, no administration of [MEDICATION NAME] was documented. During a concurrent telephone interview with the Director of Nursing (DON) and record review of Resident's Medication Administration Record (MAR) for (NAME)2019, on December 11, 2019 at 2:19 PM, the DON stated he did not see any administration of [MEDICATION NAME] for Resident A documented on the MAR. The DON stated it should be documented. Any meds given should be documented .That's the standard of practice. The DON further stated that the Licensed Vocational Nurse (LVN 1) must have administered the medication to Resident A because Resident A's blood sugar level went up to 130. During a telephone interview with LVN 1 on December 11, 2019 at 6:47 PM, LVN 1 stated if a resident's blood sugar level is low, he would go in Ekit (emergency kit containing medications like [MEDICATION NAME]) and administer [MEDICATION NAME] as ordered. LVN 1 stated all administered medications need to be signed off on the EMAR (electronic Medication Administration Record, where medications given are recorded). LVN 1 stated he should have documented when he gave the [MEDICATION NAME] on the MAR. During a review of the facility's Policy and Procedure entitled, Medication Administration, dated (NAME)2012, the policy indicated, .5. The licensed nurse shall chart the drug, time administered and initial his / her name with each medication administration and sign full name and title on each page of the Medication Administration Record (MAR) .

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.