STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING _____ B. WING _____	04/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

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 0635 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide doctor's orders for the resident's immediate care at the time the resident was admitted.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to schedule and plan a resident's appointments as ordered by the resident's physician for one of two sampled residents (Resident 2). Resident 2 had the following physician orders: 1. Sleep study (a test to diagnose sleep disorders); 2. [MEDICAL CONDITION] Function Test (PFT, a test that is designed to measure how well the lungs are working); 3. Ventilation and perfusion (V/Q, a study to test for air and blood flow in the lungs) scan; 4. Gynecology (the branch of physiology and medicine which deals with the functions and diseases specific to women and girls, especially those affecting the reproductive system); 5. Nephrology (a branch of medicine that specializes in the study of kidneys); 6. Psychiatrist (a branch of medicine that specializes in the study of mental health); 7. and arrange for catheter (a tube inserted into the body to help with different diseases). This deficient practice resulted in the resident's physician order [REDACTED]. Findings: A review of Resident 2's Admission Record indicated resident admitted to the facility on [DATE], and re-admitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 1/6/2020, indicated Resident 2 has the ability to understand and make decisions. The resident was able to eat, and dress herself, and required assistance with toileting. A review of Resident 2's, History and Physical (H&P), dated 1/1/2020, indicated Resident 2 has the capacity to understand and make decisions. During an observation and concurrent interview, on 2/15/2020 at 4:45 p.m., Resident 2 stated the general acute care hospital (GACH) instructed her to see a cardiologist (a specialist in the study of diseases of the heart), pulmonologist, and nephrologist (a specialist in nephrology). Resident 2 stated the facility did not help make any of the appointments with the specialist physicians (cardiologist, pulmonologist, and nephrologist). Resident 2 stated she has fluids in her lungs and heart. Resident 2 stated she was dependent on the oxygen (O2) and that her O2 use, increased from 2 liters per minute (LPM) to 3 LPM. Resident 2 observed with O2 at 3 LPM via nasal cannula (N/C, a tubing used to deliver O2). Resident 2 stated she wanted to go home due to not receiving follow up with consults as indicated by the GACH's orders. Resident 2 stated she was informed at the GACH that she needed a sleep study to determine if she needed to use a Continuous Positive Airway Pressure (C-PAP, a machine to treat and manage obstructive airways and stimulate normal breathing) at night while she was sleeping. During an interview and concurrent record review, on 2/15/2020 at 4:54 p.m., a Registered Nurse 1 (RN 1) stated Resident 2 discharged from the GACH and re-admitted to the facility on [DATE]. RN 1 stated Resident 2's GACH's Discharge/Transfer Documentation, dated 12/30/19 indicated Resident 2 had a physician's orders [REDACTED]., sleep study, and V/Q scan. During an interview and concurrent record review, on 2/15/2020 at 4:54 p.m., RN 1 stated that Resident 2's, Hour Report of Residents' Change of Condition and Nursing Unit Activities, dated 2/8/2020, indicated Resident 2 asked what happened to the consults the resident was supposed to have for gynecology, nephrology, PFTs, sleep study, and VQ scan. RN 1 stated Resident 2 has a [DIAGNOSES REDACTED]. RN 1 stated that she did not know and/or clarify what, arrange for cath meant. During an interview and concurrent record review of Resident 2's medical records, on 2/15/2020 at 4:54 p.m., RN 1 stated Resident 1's entire medical record, did not have any documentation indicating the facility attempted to arrange appointments for follow-up with gynecology, nephrology, a sleep study, cardiology, and V/Q scan. During an interview and concurrent record review on 2/15/2020 at 6:38 p.m., the Director of Nurses (DON) stated Resident 2 needed appointments that included a sleep study and for cath. The DON stated, I don't know what the hospital meant by arrange for cath. The DON was not able to provide documents that indicated the facility attempted to make appointments for Resident 2. The DON stated, If appointments are not documented, then they were not done. During an interview on 2/19/20 at 11:46 a.m., RN 2 stated the facility did not call to make an appointment for Resident 2's sleep study because making a gynecology appointment was more important. RN 2 stated Resident 2 was on O2 at 3 LPM for shortness of breath (SOB). A review of the facility's policy and procedures titled, Referrals, revised on 9/2005, indicated social services shall coordinate most resident referrals. Exceptions might include emergency services or specialized services arranged directly by a physician or the nursing staff. A review of the facility's policy and procedures titled, Physician Services, revised on 4/2001, indicated consultations with other health care providers will be upon the order of the attending physician of the resident.
F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure and implement the facility's discharge (DC) plan policy, prepare a resident for a safe DC and effective post-discharge care transition by not assessing and addressing a resident's pain on the left knee and left ankle, which made walking difficult for one of two sampled residents (Resident 1). This deficient practice had the potential for an unsafe discharge for Resident 1. Findings: A review of Resident 1's Admission Record indicated resident admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Pain Assessment Non-Verbal record, dated 8/15/2019, under the Interdisciplinary Team (IDT, professionals from different professional disciplines who work together to manage the physical, psychological and spiritual needs of the patient) review recommendation/comments section, indicated to monitor the resident for signs and symptoms of pain, discomfort, and administer pain medication as needed. A review of Resident 1's Pain Re-Assessment, dated 9/16/2019, indicated Resident 1 complained of pain to his left knee and left leg, occasionally moaned, or groaned, and was sad, frightened, frowned, tensed, and distressed. Resident 1's pain assessment score was a 5-moderate pain (maximum score of 10) on the non-verbal pain assessment. The document indicated the non-pharmacological interventions (dimming light, distraction, and watching television (TV)) used were not effective. Resident 1 continued to ask for pain medication. A review of Resident 1's Pain Re-Assessment, dated 10/14/2019, indicated the reason for re-assessment was for proper management of pain to left (L) ankle. Resident 1's pain scale was 5 to 7 out of 10 (5-7/10). Non-pharmacological interventions (dimming light, distraction and watching TV) used were not effective. Resident 1 needed pain medications to control pain. Resident 1 had Oxy IR ([MEDICATION NAME], a controlled substance used to treat severe pain) 10 milligrams (mg) 1 tab every (q) 4 hours (hrs) as needed (prn) for pain level of 7-10/10, and [MEDICATION NAME] (a controlled substance to treat severe pain) 10/325 mg 1 tab q 4 hrs prn for pain level of 4-6/10. A review of Resident 1's Pain Re-Assessment, dated 11/9/2019, indicated the reassessment was for, Quarterly. Resident 1 was provided non-pharmacological interventions such as dimming light, distraction and watching television (TV). The non-pharmacological interventions used were not effective. Resident 1 had Oxy IR 10 mg 1 tab orally (po) prn q 4 hrs for pain of level of 7-10/10, and [MEDICATION NAME] 10/325 mg q 4 prn for pain level of 4-6/10. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 11/20/2019, indicated Resident 1 had the capacity to understand and make decisions. The MDS indicated the resident did not walk and required one-person physical assist for bed mobility, surface transfer and for

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 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) personal hygiene. The MDS indicated the resident required extensive assistance and two plus persons physical assist to move between locations in his room and adjacent corridor and dressing. A review of Resident 1's Social Work Progress Notes indicated on 1/13/20 Resident 1 had complained that the facility would discharge him on 1/14/20. The note indicated the facility, Would ensure a safe DC, for Resident 1. A review of Physician's Telephone Order dated 1/14/20 timed 3:00 p.m., indicated to transfer Resident 1 to a lower level of care. A review of Resident 1's Social Work Progress Notes, on 1/15/20, indicated the IDT met with Resident 1 to discuss his discharge plan. The resident requested a 30-day discharge notice (noticed of proposed transfer) and refused discharge to a room and board facility (a place to live as well as meals in exchange for money, labor or other considerations). A review of Resident 1's Notice of Proposed Transfer/discharge date d 1/16/2020, indicated effective 2/15/2020, the resident to transfer/discharge to room and board. The transfer/discharge is appropriate because your health has improved sufficiently so that you no longer require services provided by this facility. A review of Resident 1's Physical Therapy (PT) Daily Treatment Note, dated from 1/26/2020 to 2/1/2020, indicated the following, on 1/28/2020, Resident 1 complained of left ankle soreness. Resident 1 demonstrated decreased step length and decreased left lower extremity (LLE) weight bearing (WB). A review of Resident 1's Pain Assessment Flow Sheet, dated from 2/1/2020 to 2/17/2020, indicated Resident 1's pain intensity was consistently at 8/10. A review of the Pain Assessment Flow Sheet from 2/1/2020 to 2/17/2020, indicated Resident 1 rated his pain at 8/10, and received Oxy IR 10 mg and [MEDICATION NAME] 10/325 mg 1 tab q 4 hrs prn for generalized body or bilateral lower extremity (BLE) pain. During an observation and concurrent interview, on 2/15/2020 at 6:05 p.m., Resident 1 observed with a gray plastic like material boot to his left foot and ankle. Resident 1 stated the Administrator (ADM), Case Manager (CM) and Social Worker (SW) continue to try to get him out of the facility since the resident's admission to the facility on [DATE]. Resident 1 stated the CM told him he could not stay at the facility. The resident stated he has a bad back problem, needs both knee replacements, and is unable to walk because of pain in his legs and swollen knees. Resident 1 observed crying. Resident 1 stated he informed PT that he could not walk because of his leg pain and that his legs would give way. During an interview and record review, on 2/15/2020 at 6:38 p.m., the Director of Nurses (DON) stated Resident 1 had a fracture (break) on the left ankle. The DON stated Resident 1's physician's orders [REDACTED]. During a telephone interview and record review, on 2/19/2020 at 11:47 a.m., the SW stated Resident 1 has been ready for discharge and does not need the facility's services anymore because the resident completed his therapy. The SW stated Resident 1's physician gave an order to discharge the resident. The SW stated, Resident 1 is ready for discharge according to the resident's PT and health insurance. During a telephone interview and concurrent record review, on 2/19/2020 at 11:47 a.m., the SW stated Resident 1's PT Daily Treatment Notes, dated on 2/5/2020 and 2/12/2020, indicated Resident 1 refused PT treatment because of pain in the left heel. The SW stated the PT notes did not indicate if the facility addressed Resident 1's pain. The SW stated she has observed Resident 1 wearing a left ankle boot. The SW stated Resident 1 had an order to wear the ankle boot. The SW stated she did not observe Resident 1 walk for two weeks, the resident does not walk, and moves around the facility in a wheel chair. During a telephone interview, on 2/19/2020 at 12:22 p.m., a PT Assistant (PTA) stated Resident 1 walked 300 feet two weeks ago and stopped walking because of left ankle pain. The PTA stated she did not notify Resident 1's physician that the resident's pain prevented the resident from walking. The PTA stated, I informed the nurses and my supervisor, that the resident complained of pain. The PTA stated, I have not worked with the Resident 1 since 2/15/2020, and that the resident wanted to visit with his physician because of his left heel pain. During a telephone interview on 2/19/2020 at 3:41 p.m., a Licensed Vocational Nurse 2 (LVN 2) stated Resident 1 always complained of a pain level of 8 out of 10. LVN 2 stated resident received [MEDICATION NAME] and [MEDICATION NAME] (a medication used to treat spasms) every two (2) hours for pain and was not relieved. LVN 2 stated the resident refused PT. LVN 2 stated Resident 1 complained to the PT Director (PTD) that there is something wrong with the resident's leg. LVN 2 stated the last time Resident 1's physician changed the resident's [MEDICATION NAME] and [MEDICATION NAME] on 10/19/2019. LVN 2 stated Resident 1's order for [MEDICATION NAME] was last changed on 9/16/2019. LVN 2 stated Resident 1 did not have a consult for pain management. A review of the facility's policy and procedure titled, Physician order [REDACTED]. Significant changes may include placing a patient on hold. A review of the facility's policy and procedure titled, Pain Management, revised on 10/2017, indicated to the facility will help a resident attain or maintain his or her highest practicable level of well-being and to prevent pain to the extent possible. Worsening of pain, the licensed nurse will notify the attending physician for further recommendations. A review of the facility's policy titled, Discharge Plan, revised 2/5/2019, indicated the care plan team will collaborate with the resident and his/her family to develop the discharge plan and anticipated discharges to same or lower level of care and discuss orientation and preparation for a safe discharge. The discharge plan will include at least the identity of specific resident needs after discharge (i.e., personal, care), a description of the resident's preferences for care, a description of how the care should be coordinated if continuing treatment involves multiple care givers and a description of how the resident and family will access and pay for such services. A review of the facility's policy and procedure titled, Transfer/Discharge Policy and Procedure, revised 2/2019, indicated the Interdisciplinary Team will meet and invite the resident and the resident representative if available to develop a plan of care designed to ensure post discharge needs were met including preferences for care, assessments for needed services, coordination of care, applicable care giver training and any alternative measures considered for accommodation of needs, safety and health of the resident and others if indicated. Social services will complete the Notice of Proposed Transfer/Discharge form and give it to the resident/resident representative prior to transfer or discharge. Social services will document discharge plans and services in accordance with the facility Discharge Planning Policy and Procedure.