STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-PALM DESERT	**74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to notify the physician when one of five sampled residents (Resident A) missed two doses of intravenous ((IV - administered through the vein) antibiotic (medicines that help stop infections caused by bacteria) medication. This failure has the potential to result in the physician not being aware of the status of treatment for [REDACTED]. Resident A stated she had missed one day of her IV antibiotic medication. Resident A's record was reviewed. Resident A was admitted on [DATE], with [DIAGNOSES REDACTED]. A review of the general progress note dated January 19, 2020, at 1:38 p.m., indicated, .to start [MEDICATION NAME] 500mg (milligrams) IVPB (intravenous piggyback - small volume of intravenous solution given by intermittent infusion) now & then QD (every day) x3days (for 3 days), then PO (per orem - oral) x 7days . A review of the Medication Administration Record [REDACTED]. The MAR (January 1 to 31, 2020) indicated the following: a. On January 20, 2020, at 9 a.m., (coded as 3 = meant out of the center); and b. On January 21, 2010 at 4 p.m. (coded as 9 = meant Other/ See Nurses notes) The Nurses note dated January 21, 2020, at 7:19 p.m., indicated, .[MEDICATION NAME] Solution .Use 500 mg .not available at this time not in our ekit (emergency kit) . On January 23, 2020, at 1:54 p.m., Registered Nurse (RN) 2 was interviewed. RN 2 stated a newly ordered medication should be started within four hours. RN 2 stated if the medication was not available at the facility, the physician should be informed. On January 23, 2020, at 3:25 p.m., the Director of Nursing (DON) was interviewed. The DON stated the licensed nurses should have notified the physician when the resident missed a dose of medication. The DON stated there was no documented evidence the physician was informed of Resident A missing two doses of [MEDICATION NAME]. On February 7, 2020, at 9:42 a.m., RN 1 was interviewed, and stated he was not able to administer Resident A's [MEDICATION NAME] dose on January 20, 2020. RN 1 stated Resident A was out of the facility. RN 1 stated on January 21, 2020, Resident A missed another dose of [MEDICATION NAME] because the medication was not available. RN 1 stated if the medication was not available the physician should be informed.
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 administer the intravenous ((IV - administered through the vein) antibiotic (medicines that help stop infections caused by bacteria) medication in accordance to the physician order [REDACTED]. Resident A stated she had missed one day of her IV antibiotic medication. Resident A's record was reviewed. Resident A was admitted on [DATE], with [DIAGNOSES REDACTED]. A review of the general progress note dated January 19, 2020, at 1:38 p.m., indicated, .to start [MEDICATION NAME] 500mg (milligrams) IVPB (intravenous piggyback - small volume of intravenous solution given by intermittent infusion) now & then QD (every day) x 3days (for 3 days), then PO (per orem - oral) x 7days . A review of the Medication Administration Record [REDACTED]. The MAR(January 1 to 31, 2020) indicated Resident A indicated the following: a. January 20, 2020, at 9 a.m., (coded as 3 = out of the center); and b. January 21, 2010 at 4 p.m. (coded as 9 = Other/ See Nurses notes). There was no documented evidence indicating the resident was offered The Nurses note dated January 21, 2020, at 7:19 p.m., indicated, .[MEDICATION NAME] Solution .Use 500 mg .not available at this time not in our ekit (emergency kit) . On January 23, 2020, at 1:54 p.m., Registered Nurse (RN) 2 was interviewed. RN 2 stated if a resident had a new order for medication, the medication should be started within four hours. RN 2 stated if the medication was not available at the facility, the physician should be informed. On January 23, 2020, at 3:25 p.m., the Director of Nursing (DON) was interviewed. The DON stated the licensed nurses should have notified the physician when the resident missed a dose of medication. The DON stated there was no documented evidence the physician was informed of Resident A missing two doses of [MEDICATION NAME]. On February 7, 2020, at 9:42 a.m., RN 1 was interviewed. RN 1 stated he was not able to administer Resident A's [MEDICATION NAME] dose on January 20, 2020. He stated Resident A was out of the facility. RN 1 stated when a resident went out during the scheduled administration of the IV medication, he should have went back to follow up and ensure the resident received the medication upon return to the facility. In addition, RN 1 stated on January 21, 2020, Resident A missed another dose of [MEDICATION NAME] because the medication was not available. He stated if the medication was not available the physician should be informed.

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.