

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/28/2024
NAME OF PROVIDER OR SUPPLIER  Country Manor Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  11723 Fenton Avenue Lake View Terrace, CA 91342	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>46445</p> <p>Based on interview and record review, the facility failed to ensure that the physician was notified when one of three sampled residents (Resident 1) had a change in condition.</p> <p>This deficient practice had the potential for delayed medical interventions for Resident 1.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 4/30/2024 with diagnoses that included urinary tract infection (UTI - an infection in any part of the urinary system [kidneys, bladder, or urethra]), benign prostatic hyperplasia ((BPH - a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream), and obstructive and reflux uropathy (occurs when urine cannot drain through the urinary tract and backs up into the kidney).</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 5/15/2024, indicated the resident ' s cognitive (mental action or process of acquiring knowledge and understanding) skills was intact. The MDS indicated Resident 1 was dependent on facility staff for toileting hygiene. The Bladder and Bowel section indicated Resident 1 had an indwelling catheter and was incontinent of bowel.</p> <p>A review of Resident 1 ' s Bowel (a long tube in the body which digested food passes from the stomach to the anus) and Bladder (a hallow organ that stores urine in the body) Evaluation, dated 5/3/2024, indicated the resident had an indwelling catheter for urinary retention or bladder outlet obstruction.</p> <p>A review of Resident 1 ' s History and Physical, dated 5/8/2024, indicated the resident had the capacity to understand and make decisions.</p> <p>A review of Resident 1 ' s Physician ' s Order, dated 5/8/2024, indicated to monitor every shift for signs and symptoms of infection such as cloudiness, bleeding, and sedimentation of the urine output.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s Care Plan on indwelling urinary catheter, initiated on 5/12/2024, indicated the resident ' s goal to be free from catheter related trauma and will not show signs and symptoms of urinary infection. The Care Plan Interventions included checking catheter tubing for kinks every shift and as needed. The Care Plan Intervention indicated to monitor, record, and report to the physician for sign and symptoms of urinary tract infection which included urine cloudiness.</p> <p>A review of Resident 1 ' s Progress Notes, dated 5/24/2024, indicated the resident had a yellow urine output with whitish sediments. There was no documentation that Resident 1 ' s attending physician was notified about the sediments in the urine output.</p> <p>On 5/28/2024 at 10:38 a.m., during a concurrent observation and interview, observed Resident 1 lying in bed, facing the right side, with white sheet covering the resident from chest down to toes, and an indwelling catheter tubing hanging on the right side of the bed frame. Certified Nursing Assistant 1 (CNA 1) removed the white sheet and Resident 1 ' s black pants and noted the catheter did not have a securement device (strap free devise which locks the catheter in place, stabilizes the catheter and eliminates any chance of sudden pull). Resident 1 was observed with feces in the disposable brief and on the bed cover. CNA 1 removed Resident 1 ' s disposable brief and picked up the pieces of feces from the resident ' s bed. Licensed Vocational Nurse 1 (LVN 1) stated that Resident 1 ' s indwelling urinary catheter output was white and cloudy.</p> <p>On 5/28/2024 at 10:50 a.m., during a concurrent observation and interview, observed Resident 1 ' s indwelling urinary catheter with Registered Nurse 1 (RN 1). RN 1 stated that Resident 1 ' s indwelling urinary catheter was not secured with a securement device and the resident ' s urine output was white to yellow in color, thick, and cloudy. RN 1 stated that Resident 1 ' s indwelling urinary catheter should be anchored on the resident's leg to prevent dislodgment and bleeding. RN 1 stated that Resident 1 ' s movement with an unsecured urinary catheter tubing had the potential to cause UTI. RN 1 stated that Resident 1 ' s urine output was a change of condition and the resident ' s attending physician was not notified.</p> <p>On 5/28/2024 at 11:23 a.m., during an interview, RN 2 stated that on 5/28/2024 at 8:30 a.m., LVN 1 reported to him that Resident 1 ' s urine output was cloudy. RN 2 stated that Resident 1 ' s urine output was not reported to the attending physician. RN 2 stated that Resident 1 ' s attending physician should be notified as soon as the resident ' s change of condition was identified.</p> <p>On 5/28/2024 at 12:36 p.m., during a concurrent interview and record review, the facility ' s policy and procedure titled, Urinary Catheter Care, dated 12/8/2023, was reviewed with the Director of Nursing (DON). The DON stated Resident 1 ' s indwelling urinary catheter should be anchored on the resident's leg to prevent pulling of the catheter, accidental dislodgement, and infection. The policy indicated to report findings to the physician or supervisor immediately.</p> <p>A review of the facility ' s policy and procedure titled, Change in a Resident ' s Condition or Status, dated 12/8/2023, indicated the facility promptly notifies the resident, his attending physician, and the resident representative of changes in the resident ' s medical/mental condition and/or status.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility ' s policy and procedure titled, Notification of Attending Physician, dated 12/8/2023, indicated the attending physician will be notified promptly by the licensed nurse by any sudden and/or marked adverse changes in signs, symptoms, or behavior exhibited by the resident. Examples of changes included . g. infections. The policy indicated that any attempts to notify the physician will be noted in the licensed nurses notes to include date, time, method of communication, specific information given to the physician based on the assessment of the resident ' s condition, person acknowledging contact, signature, and title of person who made the notification.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>46445</p> <p>Based on observation, interview and record review, the facility failed to secure a resident's urinary indwelling catheter (a flexible plastic tube inserted into the bladder that helps provide continuous urinary drainage) with a securement device (strap free device which locks the catheter in place, stabilizes the catheter and eliminates any chance of sudden pull) for one of one sampled residents.</p> <p>This deficient practice had the potential to result in urinary catheter dislodgement (forcefully pulled out of a secure position) causing urethral (the tube through which urine leaves the body) tearing resulting to possible pain, bleeding, and infection.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 4/30/2024 with diagnoses that included urinary tract infection (UTI - an infection in any part of the urinary system [kidneys, bladder, or urethra]), benign prostatic hyperplasia (BPH - a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream), and obstructive and reflux uropathy (occurs when urine cannot drain through the urinary tract and backs up into the kidney).</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 5/15/2024, indicated resident ' s cognitive (mental action or process of acquiring knowledge and understanding) skills was intact. The MDS indicated Resident 1 was dependent on facility staff for toileting hygiene. The Bladder and Bowel section indicated Resident 1 had an indwelling catheter and was incontinent of bowel.</p> <p>A review of Resident 1 ' s Bowel (a long tube in the body which digested food passes from the stomach to the anus) and Bladder (a hallow organ that stores urine in the body) Evaluation, dated 5/3/2024, indicated the resident had an indwelling catheter for urinary retention or bladder outlet obstruction.</p> <p>A review of Resident 1 ' s History and Physical, dated 5/8/2024, indicated the resident had the capacity to understand and make decisions.</p> <p>On 5/28/2024 at 10:38 a.m., during a concurrent observation and interview, observed Resident 1 lying in bed, facing the right side, with white sheet covering from chest down to toes, and an indwelling catheter tubing hanging on the right side of the bed frame. Certified Nursing Assistant 1 (CNA 1) removed the white sheet and Resident 1 ' s black pants and noted the catheter did not have a securement device(strap free device which locks the catheter in place, stabilizes the catheter and eliminates any chance of sudden pull) on Resident 1. Resident 1 was observed with feces in the disposable brief and on the bed cover. CNA 1 removed Resident 1 ' s disposable brief and picked up the pieces of feces from the resident ' s bed. Licensed Vocational Nurse 1 (LVN 1) stated that Resident 1 ' s indwelling urinary catheter should be anchored on the resident's leg with a securement device.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/28/2024 at 10:50 a.m., during a concurrent observation and interview, observed Resident 1 ' s indwelling urinary catheter with Registered Nurse 1 (RN 1). RN 1 stated that Resident 1 ' s indwelling urinary catheter did not hvae a securemnet device. RN 1 stated that Resident 1 ' s indwelling urinary catheter should be anchored on the resident's leg to prevent dislodgment and bleeding. RN 1 stated that Resident 1 ' s movement with an unsecured urinary catheter tubing had the potential to cause UTI.</p> <p>On 5/28/2024 at 12:36 p.m., during a concurrent interview and record review, the facility ' s policy and procedure titled, Urinary Catheter Care, dated 12/8/2023, was reviewed with the Director of Nursing (DON). The DON stated Resident 1 ' s indwelling urinary catheter should be anchored on the resident to prevent pulling of the catheter, accidental dislodgement, and infection. The Changing Catheter section of the policy and procedure indicated to ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site.</p>		