

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Linda Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 25383 Cole Street Loma Linda, CA 92354	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44262</p> <p>Based on interview and record review, the facility failed to report a possible overdose of narcotics for one of three sampled residents (Resident 1) per the facility policy of within 24 hours to the state agency.</p> <p>This failure had the potential for the possible overdose of narcotics to go uninvestigated and unreported thereby increasing the chances of potential harm to (Resident 1).</p> <p>Findings:</p> <p>During review of Residents 1's Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses to include: chronic respiratory failure (lungs cannot get enough oxygen), end stage renal disease (loss of kidney function), type 2 diabetes (condition affecting how body processes sugar), renal dialysis (treatment to filter blood), post-traumatic stress disorder (disorder in which a person has difficulty recovering for experiencing or witnessing a terrifying event).</p> <p>During a review concurrent interview and record review of Resident 1's Medical Record with the Director of Nursing (DON), reviewed are as follows:</p> <p>1. Nurse Note dated [DATE], at 8:25AM LATE ENTRY: Patient was sent to acute hospital for unresponsiveness with shallow breathing, Vital Signs: Blood Pressure ,d+[DATE], Pulse 93, Respirations 18, Temperature 96.9, Oxygen 67%, unprescribed and unlabeled opened bottle of pills was found on bedside table. Called paramedics at 08:00, paramedics arrived at 08:03, left at 08:15 to emergency department on gurney. Doctor and POA were notified. Power of Attorney (POA) asked if her brother had visited and stated that her brother has a history of providing patient with narcotics. When I called brother, he stated Where did he get the pills from. Bottle of pills were not noted in patient's room in undersigned's previous shift nor during change of shift when getting bedside report from NOC shift nurse on [DATE], at 07:15, then at 07:45 checked on patient again and did not notice any distress. Notice of transfer sent to Ombudsman.</p> <p>2. Situation Background Assessment Recommendation (SBAR) Communication Form /Change of Condition dated [DATE]. 2024 at 10:45: Unresponsiveness; Called 911, resident had unprescribed and unlabeled pills at bedside.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Acute hospital emergency department admitted [DATE], Diagnosis: cardiac arrest, opioid overdose intentional self-harm, initial encounter, hyperkalemia (high potassium levels), and End Stage Renal Disease. Suspected Norco overdose with cardiac arrest.</p> <p>4. Fax notification of incident dated [DATE], 10:01AM, to California Department of Public Health (CDPH) and Ombudsman. Investigation from DON dated [DATE] . Following the conclusion of this investigation, we submitted the report to CDPH as an unusual occurrence due to a verbal report from the [acute hospital] Social Worker that resident had expired at emergency room due to overdose medications despite the facility having no valid hospital clinical record. (Incident took place [DATE].)</p> <p>During an interview on [DATE], with the Director of Nursing DON (DON), the DON stated, The incident happened on [DATE], we sent out Resident 1. We were waiting for the call from the hospital and family regarding update. Then the social worker from the hospital came in on [DATE], that's the day we called the district office to report, I left a message on direct line, and I left a message on answering machine on the supervisor assigned to our facility. I faxed the reporting documents to the district office [DATE]. Yes, I can agree based on the policy reviewed, the reporting was late, it should have been reported that day.</p> <p>During a review of the facility's policy and procedure titled, Unusual Occurrence Reporting revised [DATE], the policy and procedure indicated: As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors . 2.Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations. 3.A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within forty-eight (48) hours of reporting the event or as required by federal and state regulations.</p>		