STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055401	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Post Acute	461 E. Johnston Avenue Hemet, CA 92543

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46258 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a privacy bag was used for 1 (Resident #26) of 2 sampled residents reviewed for urinary catheters. Findings included: A facility policy titled, Resident Rights, revised in 12/2016, specified, Federal and state laws guarantee certain basic rights to all resident of this facility. These rights include the resident's right to: a. a dignified existence. An Admission Record revealed the facility admitted Resident #26 on 11/04/2023. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stroke), infection of the skin and subcutaneous tissue, and sepsis (infection of the blood). A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/21/2024, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #26 was always incontinent of bladder. Resident #26's care plan included a focus area initiated 06/18/2024 that indicated the resident had an indwelling urinary catheter related to a pressure ulcer on their coccyx. Resident #26's Order Summary Report with active orders as of 06/19/2024, revealed an order dated 06/18/2024 for a Foley catheter (indwelling urinary catheter), size 16 fr. (French) attached to bedside drainage bag due to urinary retention and wound management. An observation on 06/17/2024 at 1:22 PM, revealed Resident #26 being pushed in their wheelchair from the dining room to their room. Resident #26's urinary catheter bag was observed without a privacy bag, exposing the urine. An observation on 06/18/2024 at 1:04 PM revealed Resident #26 was in the designated smoking area. Resident #26's urinary catheter bag was without a privacy bag, exposing the urine. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/2024 at 9:24 AM, Certified Nursing Assistant (CNA) #3 stated Resident #26's urinary catheter bag should be covered. During an interview on 06/20/2024 at 9:52 AM, CNA #4 revealed Resident #26 should have had a privacy bag on their urinary catheter bag. During an interview on 06/20/2024 at 10:04 AM, Licensed Vocational Nurse (LVN) #2 stated all urinary catheter bags should be covered with a privacy bag. During an interview on 06/20/2024 at 11:11 AM, the Director of Nursing (DON) stated privacy bags should always be used on urinary catheter bags. She added Resident #26 had a privacy bag and she was not sure why it was not being used. During an interview on 06/20/2024 at 12:00 PM, the Administrator stated all urinary catheter bags should have a privacy bag.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 19186 Based on record review, interview, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) (a comprehensive assessment used to develop a resident's care plan) to reflect a Preadmission Screening and Resident Review (PASRR) Level II for 3 (Residents #11, #18, and #39) of 15 sampled residents and failed to code a resident with an indwelling catheter for 1 (Resident #26) of 15 sampled residents reviewed for MDS accuracy. Findings included: A facility policy titled, Certifying Accuracy of the Resident Assessment, revised in 12/2009 revealed, All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment. The policy revealed, 1. The Assessment Coordinator must sign and certify that an MDS assessment has been completed for each resident. 2. All personnel who complete any portion of the MDS assessment, tracking form, or correction request form must sign a hard copy of such assessment certifying the accuracy of that portion of that assessment. 1. An Admission Record revealed the facility admitted Resident #11 on 01/25/2022. According to the Admission Record, the resident had a medical history that included diagnoses of major depressive disorder, schizophrenia, bipolar disorder, mood disorder due to known physiological condition, and anxiety disorder due to known physiological condition. An annual Minimal Data Set (MDS), with an Assessment Reference Date (ARD) of 01/24/2024, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS revealed that Resident #11 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS revealed the resident had active diagnoses of psychiatric/mood disorders to include anxiety disorder, depression, bipolar disorder, and schizophrenia, and had taken an antipsychotic medication during the seven-day look-back period. Resident #11's care plan included a focus area revised 05/05/2023, that indicated the resident used psychotropic medication aripiprazole for schizophrenia with mood and behavior of verbal aggression. Resident #11's Preadmission Screening and Resident Review (PASRR) Individualized Determination Report, dated 07/28/2022, revealed there were specialized services recommended to supplement the nursing facility's care to address the resident's mental health needs. The report indicated the determination was based on a review of the resident's medical and social history, which revealed a significant medical condition with mental stressors that required nursing care. The report indicated a Level II evaluation was completed on 07/28/2022. During an interview on 06/20/2024 at 8:27 AM, the MDS Coordinator stated she was aware that Resident #11 had a PASRR Level II but forgot to code it. The MDS Coordinator indicated that the PASRR was uploaded in Resident #11's electronic health record on 03/05/2024. The MDS Coordinator stated that going forward she would make sure the PASRR was uploaded in the electronic health record and will communicate with medical records staff. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/20/2024 at 10:37 AM, Medical Record (MR) #5 stated that she uploaded the PASRR information in the resident's electronic health record. She further indicated that she had a list of residents that had a PASRR Level II but was not aware if the MDS Coordinator had that list. During an interview on 06/20/2024 at 11:49 AM, the Director of Nursing (DON) stated that she used a checklist for MDS and usually focused on new admissions and readmissions. The DON stated that moving forward she will include residents with a PASRR Level II on the checklist and will provide the MDS Coordinator with the checklist. The DON further stated that it was her expectation that the MDS was coded accurately. During an interview on 06/20/2024 at 12:14 PM, the Administrator stated that it was his expectation that the MDS was coded accurately. 2. An Admission Record revealed the facility admitted Resident #18 on 10/22/2015. According to the Admission Record, the resident had a medical history that included diagnoses of major depressive disorder, schizophrenia, and personality change due to known physiological condition. An annual Minimal Data Set (MDS), with an Assessment Reference Date (ARD) of 04/19/2024 revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #18 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS revealed the resident had active diagnoses of psychiatric/mood disorders that included depression and schizophrenia and had taken an antipsychotic medication during the seven-day look-back period. Resident #18's care plan included a focus area revised 05/19/2024, that indicated the resident used psychotropic medications Zyprexa related to schizophrenia with mood and behavior of striking out. Resident #18's Preadmission Screening and Resident Review (PASRR) Individualized Determination Report, dated 03/23/2024, revealed there were specialized services recommended to supplement the nursing facility's care to address the resident's mental health needs. The report indicated the determination was based on a review of the resident's medical and social history, which revealed a significant medical condition with mental stressors that required nursing care. The report indicated a Level II evaluation was completed on 03/23/2024. During an interview on 06/20/2024 at 10:37 AM, Medical Record (MR) #5 stated that she uploaded the PASRR information in the resident's electronic health record. She further indicated that she had a list of residents that had a PASRR Level II but was not aware if the MDS Coordinator had that list. During an interview on 06/20/2024 at 11:49 AM, the Director of Nursing (DON) stated that she used a checklist for MDS and usually focused on new admissions and readmissions. The DON stated that moving forward she will include residents with a PASRR Level II on the checklist and will provide the MDS Coordinator with the checklist. The DON further stated that it was her expectation that the MDS was coded accurately. During an interview on 06/20/2024 at 12:14 PM, the Administrator stated that it was his expectation that the MDS was coded accurately. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46258 3. An Admission Record revealed the facility admitted Resident #39 on 09/15/2023. According to the Admission Record, the resident had a medical history that included diagnoses of bipolar disorder, anxiety disorder, mood disorder, and personality change due to known physiological condition. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/22/2024, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #39 did not have a PASRR Level II. Resident #39's Preadmission Screening and Resident Review (PASRR) Individualized Determination Report and letter from the State of California - Health and Human Services Agency Department of Health Care Services, both dated 09/19/2023, revealed a PASRR Level II was completed for Resident #39. Resident #39's care plan included a focus area initiated 01/31/2024 that indicated the resident had behavior management. The focus area also indicated that Resident #39 had a PASRR Level II evaluation. During an interview on 06/20/2024 at 8:27 AM, the MDS Coordinator stated a PASRR Level II should have been triggered on the MDS. During an interview on 06/20/2024 at 11:11 AM, the Director of Nursing (DON) stated the PASRR information should have been accurate on the MDS. During an interview on 06/20/2024 at 12:00 PM, the Administrator stated PASRR Level IIs should be triggered on the MDS. 4. An Admission Record revealed the facility admitted Resident #26 on 11/04/2023. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stroke), infection of the skin and subcutaneous tissue, and sepsis (infection of the blood). Resident #26's hospital Plan of Care dated 04/10/2024, revealed under the Assessment/Plan section that an indwelling urinary catheter was placed for urinary retention. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/21/2024, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #26 was always incontinent of bladder. The MDS revealed that under Appliances for bladder and bowel the Indwelling Catheter box was not check. Resident #26's Order Summary Report with active orders as of 06/17/2024, revealed an order dated 04/16/2024 to admit Resident #26 back to the facility under the direction of the Medical Director. Further review revealed no orders were present on the Order Summary Report related to the resident's urinary catheter or care related to its use. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/20/2024 at 8:27 AM, the MDS Coordinator revealed she did not notice the catheter when she interviewed Resident #26 for the significant change MDS. She stated there were no orders for the urinary catheter that would have prompt her to look for the catheter. The MDS Coordinator stated the care plans were created by what was triggered in the MDS. During an interview on 06/20/2024 at 12:00 PM, the Administrator stated that for residents with urinary catheters, the catheter should be triggered on the MDS.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46258 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a care plan was developed for 2 (Resident #26 and Resident #34) of 2 sampled residents reviewed for urinary catheters. Findings included: A facility policy titled, Care Plans, Comprehensive Person-Centered, revised in 12/2016, specified, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. The policy also indicated, The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 1. An Admission Record revealed the facility admitted Resident #26 on 11/04/2023. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stroke), infection of the skin and subcutaneous tissue, and sepsis (infection of the blood). A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/21/2024, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #26 was always incontinent of bladder. The MDS revealed that under Appliances for bladder and bowel the Indwelling Catheter box was not check. Resident #26's Progress Notes dated 04/05/2024 indicated the resident was sent to the emergency room for an evaluation of their wound. Resident #26's hospital Plan of Care dated 04/10/2024, revealed under the Assessment/Plan section that an indwelling urinary catheter was placed for urinary retention. Resident #26's Progress Notes dated 04/16/2024 revealed the resident was readmitted to the facility from the hospital. Resident #26's Order Summary Report with active orders as of 06/17/2024, revealed an order dated 04/16/2024 to admit Resident #26 back to the facility under the direction of the Medical Director. Further review revealed no orders were present on the Order Summary Report related to the resident's urinary catheter or care related to its use. Resident #26's care plan revealed that prior to survey entrance on 06/17/2024, no care plan was present for the resident's urinary catheter. An observation on 06/17/2024 at 1:22 PM, revealed Resident #26 being pushed in their wheelchair from the dining room to their room. Resident #26 was observed with a urinary catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/2024 at 8:27 AM, the MDS Coordinator revealed she did not notice the catheter when she interviewed Resident #26 for a significant change MDS. She stated there were no orders for the urinary catheter that would have prompt her to look for the catheter. The MDS Coordinator stated the care plans were created by what was triggered in the MDS. She stated it was not triggered in the MDS, so there was no prompt to create a care plan. During an interview on 06/20/2024 at 11:11 AM, the Director of Nursing (DON) stated she and the MDS Coordinator created the bulk of the care plans, but nurses have the ability to create and revise a care plan. The DON stated a care plan for Resident #26's urinary catheter should have been created. During an interview on 06/20/2024 at 12:00 PM, the Administrator stated all residents with urinary catheters should have a care plan for the urinary catheter. 28193 2. An Admission Record revealed the facility admitted Resident #34 on 07/31/2021. According to the Admission Record, the resident had a medical history that included diagnoses of obstructive and reflux uropathy and hydronephrosis with renal and ureteral calculous obstruction. A Medicare 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/21/2024, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had diagnoses of renal insufficiency, renal failure, or end stage renal disease and obstructive uropathy. The MDS revealed that under Appliances for bladder and bowel the Indwelling Catheter box was not check. A [Hospital Name] Emergency Department [ED] Record, dated 05/11/2024, revealed Resident #34 had experienced nausea and vomiting for four days. The record revealed the resident was admitted to the hospital and a urinary catheter was placed. The record revealed a urinalysis confirmed that the resident had a UTI. The record revealed Resident #34 had diagnoses of sepsis secondary to pyelonephritis and a right-sided staghorn ureteral calculus. The record revealed the ED consulted with urology for possible intervention. The record revealed the provider recommendation was for Resident #34 to have a cystoscopy with a right ureteral stent placed on 05/12/2024. The record revealed that the plan of care was to discharge the resident back to the skilled nursing facility, and to have a follow-up appointment with urology in four weeks for upsizing the resident's suprapubic catheter. Resident #34's Order Summary Report with active orders as of 06/17/2024, revealed an order dated 05/16/2024 to admit Resident #34 back to the facility under the direction of the Medical Director. The Order Summary Report revealed an order dated 05/16/2024 that indicated the resident may see a physician at a urology medical center. Further review revealed no orders were present on the Order Summary Report related to the resident's suprapubic catheter or care related to its use. Resident #34's care plan revealed that prior to survey entrance on 06/17/2024, no care plan was present for the resident's suprapubic catheter. During an interview on 06/20/2024 at 10:04 AM, Licensed Vocation Nurse (LVN) #2 stated registered nurses (RNs) created the care plans, and she updated them as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/2024 at 8:27 AM, the MDS Coordinator stated she created the care plan from MDS triggers. She stated the nurses had access to edit care plans, especially those that would be short-term, such as medication changes, and they could add interventions on already existing care plans. The MDS Coordinator stated there was no care plan created for Resident #34's urinary catheter because there was not an order for it. During an interview on 06/20/2024 at 11:08 AM, the Director of Nursing (DON) stated that she could not believe that there were no orders or care plan (prior to survey entrance on 06/17/2024) for Resident #34 and that there was no excuse for it. The DON stated that the staff had missed Resident #34's suprapubic catheter during the resident's readmission. The DON stated that staff needed to have orders, care plans, and documentation about the insertion site and lack of infection. The DON stated she should have caught that Resident #34's urinary catheter was not covered in their orders and care plan and that she took full responsibility for Resident #34's urinary catheter orders and care plan not being available for the nurses. The DON stated that she created the care plans and that the nurses had the ability to create and revise a care plan if needed. She stated her expectation was for either she or the MDS Coordinator to create the care plan and for the floor nurses to help keep them up to date. She stated she expected the care plans to be done timely and accurately and completed for everything that needed covered in a care plan. During an interview on 06/20/2024 at 12:25 PM, the Administrator stated his expectation was for care plans to be done timely and accurately.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28193 Based on observation, interview, record review, and facility policy review, the facility failed to ensure upon admission, that orders were obtained for the placement and ongoing care and maintenance of urinary catheters for 2 (Resident #34 and Resident #26) of 2 sampled residents reviewed for urinary catheters. Findings included: A facility policy titled, Catheter Care, Urinary, revised in 10/2010, revealed, The purpose of this procedure is to prevent catheter-associated urinary tract infections. The policy also revealed, The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. the name and title of the individual(s) giving the catheter care. 3. All assessment data obtained when giving catheter care. 4. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor. 5. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain, and 9. The signature and title of the person recording the data. 1. An Admission Record revealed the facility admitted Resident #34 on 07/31/2021. According to the Admission Record, the resident had a medical history that included diagnoses of obstructive and reflux uropathy and hydronephrosis with renal and ureteral calculous obstruction. A Medicare 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/21/2024, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had diagnoses of renal insufficiency, renal failure, or end stage renal disease and obstructive uropathy. The MDS revealed that under Appliances for bladder and bowel the Indwelling Catheter box was not check. Resident #34's care plan included a focus area initiated on 06/18/2024 (during the recertification survey), that indicated the resident had a suprapubic catheter related to obstructive and reflux uropathy. Interventions directed staff to position the catheter bag and tubing below the level of the bladder and away from the entrance room door, check tubing for kinks once each shift, monitor for signs and symptoms of discomfort on urination and frequency, monitor and document for pain/discomfort due to the urinary catheter, and to monitor/record/report to the doctor any signs or symptoms of a urinary tract infection (UTI) such as burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and a change in eating patterns. Further review revealed that prior to 06/18/2024, no care plan was present for the suprapubic catheter. Resident #34 returned to the facility from the hospital with a suprapubic catheter in place on 05/16/2024. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A [Hospital Name] Emergency Department [ED] Record, dated 05/11/2024, revealed Resident #34 had experienced nausea and vomiting for four days. The record revealed the resident was admitted to the hospital and a urinary catheter was placed. The record revealed a urinalysis confirmed that the resident had a UTI. The record revealed Resident #34 had diagnoses of sepsis secondary to pyelonephritis and a right-sided staghorn ureteral calculus. The record revealed the ED consulted with urology for possible intervention. The record revealed the provider recommendation was for Resident #34 to have a cystoscopy with a right ureteral stent placed on 05/12/2024. The record revealed that the plan of care was to discharge the resident back to the skilled nursing facility, and to have a follow-up appointment with urology in four weeks for upsizing the resident's suprapubic catheter. Resident #34's Order Summary Report with active orders as of 06/17/2024, revealed an order dated 05/16/2024 to admit Resident #34 back to the facility under the direction of the Medical Director. The Order Summary Report revealed an order dated 05/16/2024 that indicated the resident may see a physician at a urology medical center. Further review revealed no orders were present on the Order Summary Report related to the resident's suprapubic catheter or care related to its use. During an interview on 06/20/2024 at 10:04 AM, Licensed Vocation Nurse (LVN) #2 stated if she saw a catheter and did not have orders for it, she would contact the doctor or hospital to get orders to flush and change the urinary catheter. She stated registered nurses (RNs) created the care plans, and she updated them as needed. During an interview on 06/20/2024 at 8:27 AM, the MDS Coordinator stated she created the care plan from MDS triggers. She stated the nurses had access to edit care plans, especially those that would be short-term, such as medication changes, and they could add interventions on already existing care plans. The MDS Coordinator stated there was no care plan created for Resident #34's urinary catheter because there was not an order for it. During an interview on 06/20/2024 at 11:08 AM, the Director of Nursing (DON) stated that she could not believe that there were no orders or care plan (prior to 06/18/2024) for Resident #34 and that there was no excuse for it. The DON stated that for residents that readmit to the facility with a new urinary catheter, the nurses would complete a reassessment. The DON stated that the nurses should have become aware of Resident #34's suprapubic catheter during the admission assessment. The DON stated that the staff had missed Resident #34's suprapubic catheter during the resident's readmission. She further stated, any resident admitted with any lines such as a urinary catheter, were to be assessed and orders put in the medical record. The DON stated that staff needed to have orders, care plans, and documentation about the insertion site and lack of infection. The DON stated she should have caught that Resident #34's urinary catheter was not covered in their orders and care plan and that she took full responsibility for Resident #34's urinary catheter orders and care plan not being available for the nurses. The DON stated treatment nurses were responsible for doing urinary catheter care daily, and certified nursing assistants (CNAs) emptied the urinary catheter bags and reported the output and changes in urine to the nurse so the nurse could document on the input and output sheets. During an interview on 06/20/2024 at 12:25 PM, the Administrator stated the facility's admitting nurse should be completing a full body assessment and looking for urinary catheters. The Administrator stated once the nurses saw a urinary catheter, if it was not talked about in report, they should have called the doctor to get orders to care for the urinary catheter. The Administrator stated that the admitting nurse, an RN, or the DON should have put the orders in Resident #34's medical record. (continued on next page)

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	055401	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Post Acute	461 E. Johnston Avenue Hemet, CA 92543

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46258 2. An Admission Record revealed the facility admitted Resident #26 on 11/04/2023. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stroke), infection of the skin and subcutaneous tissue, and sepsis (infection of the blood). A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/21/2024, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #26 was always incontinent of bladder. The MDS revealed that under Appliances for bladder and bowel the Indwelling Catheter box was not check. Resident #26's Progress Notes dated 04/05/2024 indicated the resident was sent to the emergency room for an evaluation of their wound. Resident #26's hospital Plan of Care dated 04/10/2024, revealed under the Assessment/Plan section that an indwelling urinary catheter was placed for urinary retention. Resident #26's Progress Notes dated 04/16/2024 revealed the resident was readmitted to the facility from the hospital. Resident #26's Skin Observation Tool, dated 04/16/2024 did not indicate Resident #26 had a urinary catheter. Resident #26's Order Summary Report with active orders as of 06/17/2024, revealed an order dated 04/16/2024 to admit Resident #26 back to the facility under the direction of the Medical Director. Further review revealed no orders were present on the Order Summary Report related to the resident's urinary catheter or care related to its use. Resident #26's care plan included a focus area initiated 06/18/2024 (during the recertification survey), that indicated the resident had an indwelling urinary catheter related to a pressure ulcer on their coccyx. Further review revealed that prior to 06/18/2024, no care plan was present for the urinary catheter. A nursing Progress Note, dated 05/17/2024, revealed Resident #26's catheter bag was changed. The note also indicated there was no signs or symptoms of infection. An observation on 06/17/2024 at 1:22 PM, revealed Resident #26 being pushed in their wheelchair from the dining room to their room. Resident #26 was observed with a urinary catheter. On 06/18/2024 at 11:06 AM, Medical Records (MR) #5 stated there was no order for Resident #26's urinary catheter. She added she was unsure when the urinary catheter was placed but though it might have been placed during the residents last hospital stay. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/2024 at 8:27 AM, the MDS Coordinator revealed she did not notice the catheter when she interviewed Resident #26 for the significant change MDS. She stated there were no orders for the urinary catheter that would have prompt her to look for the catheter. The MDS Coordinator stated the care plans were created by what was triggered in the MDS. She stated it was not triggered in the MDS, so there was no prompt to create a care plan. During an interview on 06/20/2024 at 10:04 AM, Licensed Vocational Nurse (LVN) #2 stated Resident #26 came to the unit in April (2024) with a urinary catheter. LVN #2 stated it never triggered that Resident #26 had a urinary catheter and there was nothing in the resident's chart about it. LVN #2 stated the resident's urinary catheter should have orders and be care planned. She added that should have taken place when the resident was readmitted . LVN #2 said the treatment nurse was the one that changed the catheter, but it could be done by any nurse. During an interview on 06/20/2024 at 11:11 AM, the Director of Nursing (DON) stated that upon admission or readmission, an assessment was expected to be done. The DON stated Resident #26's Skin Observation assessment dated [DATE] was an admission/readmission assessment. The DON stated Resident #26's assessment should have noted a urinary catheter. During an interview on 06/20/2024 at 12:00 PM, the Administrator stated the admitting nurse should have done a full body assessment. The Administrator stated that a urinary catheter should have been documented at that time. The Administrator stated, additionally, the doctor should have been contacted for an order, and that should have been completed by the admitting nurse or the DON.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46258 Based on observation, interview, record review, and facility policy review, the facility failed to ensure physician orders were followed for 1 (Resident #17) of 1 resident reviewed for supplemental oxygen use. Findings included: A facility policy titled, Medication and Treatment Orders, revised in 07/2016, specified, Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in the state. A facility policy titled, Oxygen Administration, revised in 10/2010, specified, The purpose of this procedure is to provide guidelines for safe oxygen administration. The policy revealed, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. An Admission Record revealed the facility admitted Resident #17 on 02/22/2020. According to the Admission Record, the resident had a medical history that included diagnoses of shortness of breath, acute upper respiratory infection, and dependence of supplemental oxygen. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/14/2024, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #17 was on oxygen therapy. Resident #17's care plan included a focus area revised 03/15/2024 that indicated the resident was receiving continuous oxygen therapy due to shortness of breath related to an upper respiratory infection. Interventions directed staff to maintain supplemental oxygen settings at 2 liters per minute (lpm) as ordered. Resident #17's Order Summary Report with active orders as of 06/19/2024 revealed an order dated 03/31/2021 for supplemental oxygen at 2 lpm every shift for continuously low oxygen saturation. An observation on 06/17/2024 at 9:54 AM revealed Resident #17's supplemental oxygen was set at 4 lpm. An observation on 06/19/2024 at 8:43 AM revealed Resident #17's supplemental oxygen was set at 5 lpm. During an interview on 06/19/2024 at 8:47 AM, the Director of Nursing (DON) confirmed Resident #17's supplemental oxygen was set a 5 lpm. The DON then confirmed Resident #17's order indicated their supplemental oxygen should have been set at 2 lpm. She added it should be kept at 2 lpm; if Resident #17's oxygen levels were low with their current supplemental oxygen order then a new order should be received from the doctor prior to changing Resident #17's supplemental oxygen settings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/2024 at 10:04 AM, Licensed Vocational Nurse (LVN) #2 stated supplemental oxygen levels should not be changed unless there was a physician's order for the change. She added she had no idea why Resident #17's supplemental oxygen setting was set so high. During an interview on 06/20/2024 at 12:00 PM, the Administrator stated all orders needed to be followed. The Administrator stated if a resident had low oxygen saturation levels with the current supplemental oxygen order, the doctor should be notified, and a new order obtained.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 28193 Based on interview, record review, and facility policy review, the facility failed to ensure staff assessed a resident's condition and monitored for complications before and after dialysis treatments and failed to ensure there was ongoing communication and collaboration with the dialysis center regarding dialysis care and services for 1 (Resident #53) of 1 sampled resident reviewed for dialysis. Findings included: A facility policy titled, Care of Resident on Renal Dialysis, revised in 06/2016, revealed, It is the policy of this facility to provide standards in the care of the residents on renal dialysis and the care of the vascular access site for hemodialysis. The policy revealed, under Documentation, 2. Facility Licensed Nurse will complete the baseline information, pre and post dialysis section of the Nurses Dialysis Communication Record. 3. Dialysis Center Licensed Nurse will complete the dialysis center section of the Nurses Dialysis Communication Record. An Admission Record revealed the facility admitted Resident #53 on 04/26/2024. According to the Admission Record, the resident had a medical history that included end stage renal disease (ESRD), hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease, acute kidney failure, and dependence on renal dialysis. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/03/2024, revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had a diagnosis of renal insufficiency, renal failure, or ESRD and was dependent on dialysis. Resident #53's care plan included a focus area initiated 05/17/2024, that indicated the resident needed hemodialysis related to acute kidney failure, acute kidney injury, chronic kidney disease stage 3, hypertension, and abnormal lab values for BUN (blood urea nitrogen) and creatinine. The focus area revealed the resident had a tunneled CVC (central venous catheter) for hemodialysis in the right chest that was placed on 04/25/2024. Interventions directed staff to encourage Resident #53 to go to scheduled dialysis appointments; monitor labs and report to the doctor as needed; monitor, document, and report any signs or symptoms of infection to the access site, such as redness, swelling, warmth, or drainage; to monitor, document, and report signs or symptoms of renal insufficiency, such as changes in level of consciousness, skin turgor, oral mucosa, or heart and lung sounds; to monitor, document, and report any signs or symptoms of bleeding, hemorrhage, bacteremia (infection of the blood), or septic shock; and for the presence of unusual bleeding on catheter site, apply direct pressure over bleeding site till bleeding stops; if bleeding does not stop call 911 and notify the dialysis center. Resident #53's Order Summary Report with active orders as of 06/17/2024 revealed an order dated 04/27/2024 for dialysis on Mondays, Wednesdays, and Fridays. Resident #53's Dialysis Assessment Record for the timeframe from 05/01/2024 through 06/12/2024 revealed the following: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The Dialysis Assessment Record dated 05/01/2024, 05/03/2024, 05/17/2024, and 05/20/2024, revealed the Dialysis Nurse and Post-Dialysis Assessment (Facility Nurse) sections had not been completed. - The Dialysis Assessment Record dated 05/06/2024 and 05/08/2024 revealed that the pre-dialysis and post-dialysis assessment sections of the record were incomplete and were missing information regarding the vascular access site and the vascular access site assessment. The Dialysis Assessment Record dated 05/10/2024 revealed that the post-dialysis assessment section of the record was incomplete and was missing information regarding the vascular access site and the vascular access site assessment. - The Dialysis Assessment Record dated 05/03/2024, 05/08/2024 and 05/24/2024 revealed that the pre-dialysis assessment weight information was not completed. - The Dialysis Assessment Record dated 05/27/2024 and 06/12/2024, revealed the pre-dialysis assessment vital signs information was not completed. - The Dialysis Assessment Record dated 05/01/2024, 05/03/2024, 05/08/2024, 05/20/2024, 05/31/2024, 06/07/2024, and 06/12/2024, revealed that the pre-dialysis assessment last mealtime information was not completed. A nursing Progress Note dated 05/24/2024 at 6:52 PM revealed Resident #53 had returned from dialysis at 4:48 PM and after 30 minutes had vomited. The note revealed an order for Zofran (a medication for nausea) was ordered. A Dialysis Assessment Record dated 05/27/2024 revealed there was no documentation of the episode of vomiting 30 minutes after returning from dialysis on 05/24/2024. Resident #53's Progress Notes revealed a SBAR [Situation, Background, Assessment, and Recommendation] Summary, dated 06/03/2024 at 7:30 PM, that indicated Resident #53 had a change of condition. The summary revealed following dialysis, the resident's blood pressure had dropped to 82/52 mmhg (millimeters of mercury). The summary revealed the primary care physician was notified and recommended Midodrine 10 mg (milligrams) three times a day. A nursing Progress Note dated 06/04/2024 at 10:43 PM revealed Resident #53 had a blood pressure at 4:00 PM of 88/50 mmhg, Midodrine was given, and the resident's blood pressure was rechecked and was 103/65 mmhg. Resident #53's Dialysis Assessment Record dated 06/05/2024 revealed there was no documentation of the low blood pressure incidents from 06/03/2024 and 06/04/2024, nor the addition of Midodrine 10 mg three times a day for low blood pressure. A nursing Progress Note dated 06/06/2024 at 10:39 PM, revealed Resident #53's blood pressure was 94/56 mmhg at 4:00 PM. A Dialysis Assessment Record dated 06/07/2024 revealed there was no documentation of the incident of low blood pressure on 06/06/2024. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing Progress Note dated 06/10/2024 at 10:56 PM, revealed Resident #53 came back from dialysis, and their blood pressure was 78/53 mmhg. The note revealed Midodrine was given, and that resident's blood pressure was rechecked and was 97/55 mmhg. Resident #53's Dialysis Assessment Record dated 06/12/2024 revealed there was no documentation of the low blood pressure incident on 06/10/2024 right after dialysis. During a phone interview on 06/19/2024 at 8:45 AM, Dialysis Technician (DT) #1 stated the facility was not good at communication regarding Resident #53. She stated that on 06/17/2024, during the afternoon following the surveyors' entrance, the facility faxed over several Dialysis Assessment Records that were not completed and asked for them to be filled out and faxed back. DT #1 stated they were not able to fill out information all the way back to 05/01/2024 and would not be sending the sheets back to the facility completed. She stated the dialysis center was not made aware of Resident #53's low blood pressure readings, the new order for Midodrine 10 mg three times a day to treat low blood pressures, the episode of nausea and vomiting following dialysis, or the order for Zofran. DT #1 further stated that dialysis staff would have wanted to know that information, especially regarding the low blood pressure, as it would indicate the dialysis center would need to be more gentle in pulling the amount of fluid they were pulling from Resident #53. During an interview on 06/20/2024 at 10:04 AM, Licensed Vocational Nurse (LVN) #2 stated she had worked at the facility for nine years and the protocol for a dialysis resident was to know where they were going to receive treatment, contact transportation, get the fluid restrictions in place, and to tally intakes and outputs. She stated the nurse on duty was to fill out the sheet (Dialysis Communication Assessment) to include the last time the resident ate, if they had any edema (swelling), and bruit and thrill. LVN #2 stated that dialysis staff would want to know if the resident was nauseous or if their blood pressure was running low, so they could take precautions while they were there. During an interview on 06/20/2024 at 11:08 AM, the Director of Nursing (DON) stated that the communication provided between the dialysis center and the facility should be a baseline weight and vitals. The DON stated the middle portion of the Dialysis Communication Record was where the dialysis center would write what went on during the treatment and make suggestions based on the resident's needs. The DON stated the nurses were supposed to check the vascular access site for bleeding and take an additional set of vitals to ensure the resident was stable. She stated the dialysis center should know about a resident being nauseous or vomiting after treatments and if their blood pressure kept going low. During an interview on 06/20/2024 at 12:25 PM, the Administrator stated his expectation for residents who required dialysis was when the resident came back to the facility, the nurses should be assessing them for bleeding.