STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055807	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shasta View Estates	445 Park Street Weed, CA 96094

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide appropriate treatment and care according to orders, resident's preferences and goals. 43755 Based on interview and record review, the facility failed to ensure that there was an alternative system in place by which resident Medication Administration Records (MARs), Treatment Administration Records (TARs), and Physician's Orders, could be accessed by staff in the event that the facility's Electronic Medical Record system (EMR, a computerized system that contained resident MARs, TARs, and Physician's Orders), was not available for 41 of 41 residents. On 7/17/24, the facility's EMR system administrator notified the facility that there was going to be a scheduled outage for EMR maintenance and that the EMRs would not be available on 7/18/24. The facility took no action to prepare for this planned outage and subsequently had no way for the nurses to administer medications, treatments (wound and skin care), or see what the physician currently had ordered for each resident. This failure resulted in the nursing staff ' s inability to know what each resident ' s current physician ' s orders were, therefore, the nursing staff was unable to administer medications or do wound care treatments for all residents, which had the potential for the residents to experience unnecessary pain, untreated blood sugar levels, breathing difficulties, anxiety and depression, which could negatively impact their physical, emotional, and psychosocial well-being. An Immediate Jeopardy (IJ- when the facility's non-compliance has the potential to cause serious injury, harm, impairment or death) situation was identified on 7/19/24 at 5:55 pm, in the presence of the Administrator (Admin), because the facility's EMR system had been unavailable and the residents had not received their physician ordered medications and treatments, for 19 hours. An IJ removal plan to immediately correct this problem was requested from the Admin. An IJ removal plan was provided by the Admin and accepted on 7/22/24 at 1:37 pm. The facility obtained a designated computer that worked off line (no internet was needed), and this computer would not be affected by EMR system outages, because the EMR information could be stored in that computer's hard drive (a self contained storage device). This off line computer downloads resident EMR information every 15 minutes and paper MARs, TARs and Physician's Orders for all residents can be printed on paper by the nurses and avoid delayed medications and treatments. The IJ removal plan was verified by the surveyor while on site to be fully implemented. The IJ was removed on 7/22/24 at 2:47pm. Findings: (continued on next page)

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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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the facility's policy titled, Electronic Medical Records dated March 2014, indicated Electronic medical records may be used in lieu of paper records when approved by the Administrator. The Administrator, in conjunction with the Quality Assessment and Assurance Committee (a group of facility managers that identify problems and develop actions to correct them), shall review requests for and the implementation of our electronic medical records system. A review of the facility ' s policy titled, Charting and Documentation dated July 2017, indicated, The following information is to be documented in the resident medical record: medications administered; treatments or services performed, changes in the resident ' s condition . During an interview on 7/19/24 at 2:30 pm, the Admin indicated their EMR system had been inaccessible since 7/18/24 at 3:00 pm, for 23 and a half hours. Admin stated, we are working on it. Admin confirmed the facility did not have access to all residents ' Physician ' s Orders, MARs and TARs. Admin indicated he did not have a policy with instructions on what to do during an EMR system outage. During an interview on 7/19/24 at 2:50 pm, with Resident 1 in her room, she indicated she had not received any medications yet today. Resident 1 indicated she usually took about 6 medications after breakfast, and she had not received them yet. Resident 1 indicated that last night she was told by an evening shift nurse, the computers were down. Resident 1 indicated she was anxious because, although she did not know the names of her medications, she had not received her heart medications. During an interview on 7/19/24 at 2:52 pm, with Resident 2 in her room, she indicated she did not think she got her morning or lunch medications today. Resident 2 indicated she did not get her stool softener last night or today and she was feeling constipated (unable to have a bowel movement), and that worried her. During an interview on 7/19/24 at 3:00 pm, with Resident 3 in his room, he indicated he did not get his evening medication on 7/18/24 or his morning medications today. Resident 3 indicated he was concerned because he had a condition called gout which caused pain in his left great toe. Resident 3 indicated he had not received the medication for his gout and his toe was hurting. During an interview on 7/19/24 at 3:14 pm, Certified Nursing Assistant (CNA) A indicated the nurse informed her today, 7/19/24, that residents were not getting their medications due to the EMR system outage. CNA A indicated she was very concerned about residents who had aggressive and wandering (moving to an unsafe area in the facility or even outside without staff knowledge), behaviors. During an interview on 7/19/24 at 3:14 pm, Licensed Vocational Nurse (LVN) B indicated that the EMR system went down yesterday on 7/18/24 around 3:00 pm. LVN B indicated the nurses were unable to administer current medication, provide wound treatments or respiratory treatments (inhalers and medication in breathing machines), because they did not have access to any residents' current MARs, TARs, and Physician ' s Orders. LVN B indicated she had checked the resident ' s paper charts (a binder that contained printed medical records for a resident), to retrieve current physcian's orders but the most recent orders she could find were April 2024 (90 days ago). LVN B indicated there should have been current printed Physician ' s Orders, that were signed by the physician, and placed in all residents' paper chart, but this had not been done. LVN B confirmed there was no back up system for the EMR, so they had no way of knowing what the current orders were for all 41 residents. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 7/19/24 at 3:25 pm, LVN D indicated they were unable to chart resident ' s conditions, administer medications, do wound care and respiratory treatments because the EMR system had stopped working on 7/18/24 around 3:00 pm. During an interview on 7/19/24 at 3:42 pm, the Admin stated, we thought we had back up orders for medication through our pharmacy but apparently, they had not updated them. During an interview at 7/19/24 at 3:50 pm, LVN B indicated that at 10:00 am 7/19/24, Resident 4 became diaphoretic (sweaty) and shaky. His blood sugar was recorded at 250 mg/dL (milligram per deciliter, a measurement) (According to the American Diabetes Association ' s goals for blood sugar control in people with diabetes are 70-130 mg/dl before meals .). LVN B indicated Resident 4 ' s blood sugar level required the Physician to be notified. LVN B indicated that Resident 4 had not been able to receive his usual blood sugar medication as ordered because of the EMR system outage. During an interview on 7/19/24 at 3:56 pm, Business Office Manager (BOM) indicated she had received a warning message on 7/17/24, that the facility's EMR system was scheduled for a planned outage that would occur on 7/18/24 at 1:00 am. BOM stated the warning indicated the following, As best practice we recommend running your eMAR [electronic Medication Administration Record] offline report [transferring MARs and TARS to a computer that can be accessed when the internet system was not working, which would allow the MARs and TARs to be printed and accessible to the nurses] to ensure it is installed and functioning properly for use during the outage. BOM indicated the EMR system would post this alert every time there were planned outages for updates to the EMR system. BOM indicated that this EMR warning was able to be seen on all computers that the nurses used and remained on their computer until the user responded to the message. The BOM indicated that these warnings from their EMR system provider get ignored because the outages only usually last about 2 hours. BOM added that there was also a global internet outage (disruptions across the world), which occurred on the same day, 7/18/24, which contributed to their EMR system being unavailable for a longer period than expected. During an interview with the Admin and a review of the facility ' s Emergency Preparedness/Disaster plan on 7/19/24 at 4:51 pm, the Admin indicated that there was nothing in the facility ' s disaster plan concerning what to do if the EMR system stopped working, but there should have been. The Admin stated, we are just in the process of rewriting it [the facility ' s Emergency Preparedness/Disaster plan manual]. During a phone interview with the Medical Director (MD) on 7/19/24 at 5:15 pm, MD indicated she does not have access to the EMR system that the facility uses. MD stated, I use a different system for EMR information than the facility does. It is not my job to know if the facility has a backup system for their EMR. The MD indicated that she was informed of the EMR outage by LVN C on 7/19/24 at 10:00 am. The MD indicated she gave LVN C directions to administer medications to all of the residents by using the directions on their medication cards (the container labeled by the Pharmacist that the medications are packaged in, from the Pharmacy), instead of using a MAR. During a phone interview with the Pharmacist (PM) on 7/19/24 at 5:43 pm. The PM indicated he was notified of the facility's EMR system outage by his supervisor at 3:00 pm on 7/19/24. PM indicated that he had began working on updating the Physician ' s Orders for the residents at that time. The PM indicated that the resident's medication card labels did not always have the correct or current directions, and should not be used to administer medications to residents. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with the Admin and record review on 7/19/24 at 5:55 pm, the facility ' s manual titled, What to do in case of [EMR system] down time was reviewed. The Admin confirmed that there was no information about an offline EMR backup system that could be accessed and used or directions on how to print all MARs, TARs, and Physician ' s Orders on paper. The Admin indicated that this was a very serious situation because residents were not receiving medication or treatments which were important to their well-being. During an interview on 7/22/24 at 2:20 pm, the Director of Nursing Services (DNS), indicated the EMR system was offline for a total of 30 hours. DNS stated, [LVN E] let me know [that the EMR system was down] on Thursday [7/18/24] at 4:14 pm. At that time, I did not realize it was going to be off for an extended amount of time. It had not even crossed my mind that this would ever happen so, no, we have no backup. The DNS indicated that she does receive EMR system outage warnings regularly, that she does not read. DNS stated, I got emails and alerts [from the EMR system], about this [EMR system outage] but I do not know what it said. The DNS indicated that she usually printed off current Physician's Orders at the beginning of each month but she had, gotten off track and May, June and July ' s Physician ' s Orders had not been printed. DNS stated, It has been very busy.