

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Pacific Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3355 Pacific Place Long Beach, CA 90806	
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028</p> <p>Based on interview and record review, the facility failed to notify the physician and/or the Nurse Practitioner (NP) when one of three sampled residents (Resident 1) aspirated (accidentally inhaling food or liquid through the vocal cords into the airway instead of swallowing through the food pipe) and vomited during feeding.</p> <p>This deficient practice resulted in a delay in treatment and a delay in transfer to a General Acute Care Hospital (GACH) for further evaluation and had the potential for Resident 1 to develop aspiration pneumonia (a type of pneumonia that occurs when a person breathes in food, liquid, or other substances into their lungs instead of swallowing them).</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including acute (sudden onset) respiratory failure (a serious condition that makes it difficult to breathe on your own), tracheostomy (a hole that surgeons make through the front of the neck and into the trachea [windpipe] to insert a tube to provide an air passage to help a person breathe when the usual route for breathing is somehow blocked or reduced) status, and ventilator (a device that helps you breathe) dependence.</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 12/17/2023, the MDS indicated Resident 1's cognitive skills for decision making were severely impaired and she did not have the ability to understand or be understood by others. The MDS indicated Resident 1 required mechanical ventilation, suctioning (removing mucous and other fluids from the windpipe and large airways), and oxygen (O2) therapy.</p> <p>During a review of Resident 1's History and Physical (H&P) dated 12/14/2023, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Continuous Ventilator Flow Sheet dated 1/15/2024 and timed at 11:30 a.m., the Continuous Ventilator Flow Sheet indicated Resident 1 aspirated during feeding.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056007
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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>During a review of Resident 1's Subacute Daily Nursing assessment dated [DATE], the Subacute Daily Nursing Assessment indicated Licensed Vocational Nurse 1 (LVN 1) documented Resident 1 did not tolerate the bolus feeding (a large dose of formula feedings though the feeding tube using a catheter syringe) and vomited. The Subacute Daily Nursing Assessment indicated LVN 1 notified Registered Nurse Supervisor 1 (RNS 1) of Resident 1's inability to tolerate the bolus feeding and of Resident 1's episode of vomiting.</p> <p>During a review of Resident 1's clinical record, there was no documentation indicating Resident 1's physician or NP was notified by RNS 1 or LVN 1 after Resident 1's episode of vomiting and aspiration.</p> <p>During a review of Resident 1's Licensed Personnel Weekly Progress Notes dated 1/15/2024 and timed at 8 p.m., the Licensed Personnel Weekly Progress Notes indicated Resident 1's respiratory rate (RR) was 40 breaths per minute (normal RR is between 18-20 breaths per minute). The Licensed Personnel Weekly Progress Notes indicated the NP was made aware of Resident 1's elevated RR, however there was no documentation indicating the NP was informed of Resident 1's episode of vomiting and aspiration. The Licensed Personnel Weekly Progress Notes indicated the NP recommended Resident 1 be transferred to a GACH for further evaluation.</p> <p>During a review of Resident 1's Licensed Personnel Weekly Progress Notes dated 1/15/2024 and timed at 8:15 p.m., the Licensed Personnel Weekly Progress Notes indicated RNS 2 was notified by Respiratory Therapist 1 (RT 1) that Resident 1 aspirated during the bolus feeding at 11:30 a.m. The Licensed Personnel Weekly Progress Notes indicated there was no documentation by the RNS 2 indicating Resident 1's physician or the NP was immediately notified.</p> <p>During a review of Resident 1's Licensed Personnel Weekly Progress Notes dated 1/15/2024 and timed at 8:40 p.m., the Licensed Personnel Weekly Progress Notes indicated Resident 1 was transferred to a GACH via 911.</p> <p>During a telephone interview on 6/25/2024 at 9:44 p.m., RNS 2 stated he should have informed Resident 1's NP immediately after the RT 1 notified him of Resident 1's episode of vomiting and aspiration. RNS 2 stated he did not find it necessary to notify the NP that Resident 1 aspirated because he did not think Resident 1's aspiration contributed to Resident 1's elevated RR.</p> <p>During an interview on 6/26/2024 at 3:29 p.m., LVN 1 stated she notified RNS 1 immediately after Resident 1 vomited during the bolus feeding but stated she did not follow up to confirm if RNS 1 notified Resident 1's physician or NP. LVN 1 stated she could have notified Resident 1's physician or NP herself, but usually the RNS' are in charge of notifying the physician or NP when a resident has a change of condition (COC).</p> <p>During an interview on 6/26/2024 at 5:44 p.m., the Director of Nursing (DON) stated licensed nurses are responsible for notifying the physician or NP when residents have a COC so the physician or NP could treatment immediately and/or have the resident transferred to a GACH for further evaluation.</p> <p>During a phone interview on 6/27/2024 at 12:13 p.m., the NP stated if the licensed nurses had notified her that Resident 1's aspirated and vomited, she would have recommended that Resident 1 be transferred to a GACH immediately for evaluation and treatment. The NP stated when a resident aspirates, there was a potential for respiratory distress and aspiration pneumonia if not treated promptly.</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>During a review of the facility's policies, the facility had no policy that addressed notifying the physician of a resident's COC.</p>

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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>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** 45028</p> <p>Based on interview and record review, the facility failed ensure the Respiratory Therapist ([RT] a medical professional who works with patients who have breathing problems or other lung conditions) obtained orders from the physician/nurse practitioner (NP) prior to changing ventilator settings (used ot control how much and how fast air is delivered to a patient's lungs) for one of three sampled residents (Resident 1) and Registered Nurse Supervisor 1 (RNS 1) and RNS 2 followed the recommendations of Resident 1's NP to transfer Resident 1 to a General Acute Care Hospital (GACH) when Resident 1's respiratory rate (RR) was abnormal and showed no signs of improvement.</p> <p>These deficient practices resulted Resident 1 receiving treatment that was not prescribed by Resident 1's physician or NP and a delay in transferring Resident 1 to a GACH for evaluation and treatment. This deficient practice had the potential for Resident 1's respiratory status to deteriorate resulting.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including acute (sudden onset) respiratory failure (a serious condition that makes it difficult to breathe on your own), tracheostomy (a hole that surgeons make though the front of the neck and into the trachea [windpipe] to insert a tube to provide an air passage to help a person breathe when the usual route for breathing is somehow blocked or reduced) status, and ventilator (a device that helps you breathe) dependence.</p> <p>During a review of Resident 1's History and Physical (H&P) dated 12/14/2023, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 12/17/2023, the MDS indicated Resident 1's cognitive skills for decision making were severely impaired and she did not have the ability to understand or be understood by others. The MDS indicated Resident 1 required mechanical ventilation, suctioning (removing mucous and other fluids from the windpipe and large airways), and oxygen (O2) therapy.</p> <p>During a review of Resident 1's Order Summary Report (Physician's Orders) dated 12/28/2023, the Physician's Orders indicated the following ventilator settings for Resident 1:</p> <ol style="list-style-type: none"> 1. Assist Control ([AC] the number of breaths a patient is receiving from a breathing machine (ventilator) 2. Respiratory Rate ([RR] the number of breaths per minute a ventilator will deliver to a patient) of 18 breaths per minute. 3. Tidal Volume ([VT] the amount of air a person inhales during a normal breath) of 400. 4. Fraction of Inspired Oxygen ([FiO2] a ventilator setting that controls the percentage of O2 delivered to a patient) of 40% - 5 liters per minute (lpm) <p>(continued on next page)</p>		

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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>During a review of Resident 1's Licensed Personnel Weekly Progress Notes dated 1/15/2024 and timed at 8:30 p.m., the Licensed Personnel Weekly Progress Notes indicated Resident 1's RR was between 35-41 breaths per minute. The Licensed Personnel Weekly Progress Notes indicated Resident 1's FM 1 and FM 2 requested that Resident 1 be transferred to a GACH.</p> <p>During a review of Resident 1's Licensed Personnel Weekly Progress Notes dated 1/15/2024 and timed at 8:40 p.m., the Licensed Personnel Weekly Progress Notes indicated RNS 2 called 911 (at least an hour and 40minutes after Resident 1's RR increased as evidenced by documentation on the Licensed Personnel Progress Notes at 7 p.m.).</p> <p>During an interview on 6/24/2024 at 3:02 p.m., FM 2 stated on 1/15/2024 she requested several times that Resident 1 be transferred to a GACH via 911 but the licensed nurses refused to transfer Resident 1.</p> <p>During a telephone interview on 6/25/2024 at 9:44 p.m., RNS 2 stated he did not think it was necessary to transfer Resident 1 to a GACH on 1/15/2024 at 7:30 p.m. RNS 2 stated he knew ventilator settings were only to be changed with a physician's or NP's order, but he wanted to implement interventions that would hopefully stabilize Resident 1 because he (RNS 2) did not want to prematurely call 911 to transfer Resident 1 to a GACH. RNS 2 stated Resident 1 was still somewhat stable so he decided to have RT 1 change Resident 1's ventilator settings and if Resident 1's respiratory status did not improve he would call Resident 1's NP for further orders. RNS 2 stated he did not think it was necessary to transfer Resident 1 to a GACH on 1/15/2024 at 8 p.m., after Resident 1's NP's recommendation to transfer Resident 1 to a GACH because Resident 1 was not showing signs of respiratory distress and he wanted to continue the interventions to see if Resident 1's status improved.</p> <p>During an interview on 6/26/2024 at 2:17 p.m., RT 1 stated on 1/15/2024, he recommended to RNS 1 on several occasions throughout the shift (7 a.m., - 7 p.m.) that Resident 1 be transferred to a GACH for further evaluation and management because Resident 1's RR was not improving, but RNS 1 did not agree with his recommendation. RT 1 stated because Resident 1 was not improving, he recommended to RNS 2 on 1/15/2024 at 7 p.m., that Resident 1 be transferred to a GACH, but RNS 2 did not agree with his recommendation.</p> <p>During a phone interview on 6/26/2024 at 4:44 p.m., RNS 1 stated she did not feel the need to transfer Resident 1 to a GACH after the NP recommendation to transfer her because she (RNS 1) felt Resident 1 was stable.</p> <p>During an interview on 6/26/2024 at 5:44 p.m., the Director of Nursing (DON) stated based on Resident 1's status and the recommendation made by the NP, Resident 1 should have been transferred to a GACH because Resident 1 was not improving. The DON stated licensed nurses, nor the RTs can change a ventilator setting without a physician's or NP's order because that was not within their scope of practice. The DON stated Resident 1 had the potential for cardiac arrest from increased carbon dioxide (colorless odorless gas that is a waste product of the body) in the blood due to an increased RR.</p> <p>During a review of the facility's undated policy and procedure (P&P) titled, Mechanical Ventilation, the P&P indicated ventilator changes are to be made only with a written physician's order and by respiratory care provider.</p> <p>(continued on next page)</p>		

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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>During a review of the facility's P&P titled, Physician Orders and Telephone Orders, dated 11/2017, the P&P indicated physician's orders shall be obtained prior to the initiation of any medication or treatment from a person lawfully authorized to prescribe for and treat human illness.</p> <p>During a review of the facility's P&P titled, Change of Condition, revised 3/2021, the P&P indicated the physician is responsible for making the decision for the resident to be treated at the facility or be transferred to the acute hospital for treatment.</p>