

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER Lone Tree Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 Lone Tree Way Antioch, CA 94509	

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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>45555</p> <p>Based on observations, interviews, record review, and facility policy review, the facility failed to ensure the baseline care plan included the primary diagnosis and related respiratory treatments for 1 (Resident #267) of 19 sampled residents.</p> <p>Findings included:</p> <p>A review of the facility policy titled, Care Plans - Baseline, revised in December 2022, revealed, Statement A baseline plan of care should be developed for each resident within forty-eight (48) hours of admission. Interpretation and Implementation 1. The baseline care plan should include instructions needed to provide effective, person-centered care of the resident, which may include the following: a. Initial goals based on admission orders and discussion with the resident/representative. b. Physician orders; c. Dietary orders; d. Therapy services; e. Social Services; and f. PASARR [Preadmission Screening and Resident Review] recommendation, if applicable.</p> <p>A review of Resident #267's Admission Record revealed the facility admitted the resident on 12/01/2023 with a primary diagnosis of pulmonary coccidioidomycosis (a fungal infection in the lungs).</p> <p>A review of Resident #267's physician orders revealed an order dated 12/01/2023, for DuoNeb solution 0.5 - 2.5 milligram (mg) per three milliliters, inhale one application orally by way of a nebulizer every four hours as needed for wheezing; fluconazole tablet 200 mg, give one tablet by way of percutaneous endoscopic gastrostomy tube one time a day every Tuesday, Thursday, and Sunday for pulmonary cocci (bacteria); and oxygen at 2 liters per minute by way of nasal cannula as needed. The resident also had an order dated 12/02/2023 that directed staff to suction the resident as needed.</p> <p>A review of Resident #267's baseline care plan, with an effective date of 12/03/2023, revealed the baseline care plan did not address the resident's respiratory diagnosis, the need to be suctioned as needed, or the orders for the use of oxygen or nebulizer treatments.</p> <p>On 12/04/2023 at 11:30 AM and 12/05/2023 at 1:21 PM, the surveyor observed a suction machine on the nightstand in Resident #267's room.</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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/06/2023 at 2:22 PM, the Minimum Data Set (MDS) Nurse #4 stated baseline care plans were completed upon admission and should include a resident's medications, diagnoses, fall risk, code status, and treatments to include wounds, nebulizers, oxygen use, and suctioning. MDS Nurse #4 stated Resident #267's baseline care plan should have included suctioning.</p> <p>During an interview on 12/06/2023 at 1:53 PM, the Assistant Director of Nursing (ADON) stated the baseline care plan was initiated by the MDS nurse upon admission and the other departments were responsible for completing their sections. The ADON stated she would expect the primary diagnosis and treatments being done to be included on the baseline care plan. Per the ADON, the use of oxygen, nebulizers, and suctioning should be on the baseline care plan, and she was not sure why it was not included on Resident #267's baseline care plan.</p> <p>During an interview on 12/06/2023 at 2:00 PM, the Director of Nursing (DON) stated baseline care plans were initiated by the MDS nurse on the day of admission and should include a resident's primary diagnosis and treatments provided. The DON stated suctioning, oxygen use, and nebulizer use should be included on the baseline care plan.</p> <p>During an interview on 12/06/2023 at 2:31 PM, the Administrator stated he expected baseline care plans to include the general plan of care dependent on the resident's diagnosis and orders.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>45555</p> <p>Based on observations, interviews, record reviews, and facility policy review, the facility failed to have a medication error rate less than 5%. The facility had 2 medications errors out of 27 opportunities, which yielded a medication error rate of 7.41% for 2 (Resident #8 and Resident #52) of 6 residents observed for medication administration.</p> <p>Findings included:</p> <p>A review of the facility policy titled, Administering Medications, revised in April 2023, revealed, 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.</p> <p>A review of Resident #52's physician orders revealed an order dated 11/09/2023, for Aspirin 81 milligrams (mg) delayed release, give one tablet by mouth one time a day for stroke prevention.</p> <p>During medication administration observation on 12/06/2023 at 7:58 AM, Licensed Vocational Nurse (LVN) #1 did not administer Aspirin 81 mg to Resident #52.</p> <p>During an interview on 12/06/2023 at 12:10 PM, LVN #1 stated he thought he had given the Aspirin to Resident #52. LVN #1 stated he should have done the five checks of medication pass, to include checking for the right resident, medication, dose, time, and route to ensure all medications were prepared for administration.</p> <p>A review of Resident #8's physician orders revealed an order dated 11/22/2023, for fluticasone propionate nasal suspension 50 micrograms per actuation, one spray in both nostrils one time a day for nasal allergy.</p> <p>During medication administration observation on 12/06/2023 at 8:19 AM, LVN #2 did not administer fluticasone propionate nasal suspension to Resident #8.</p> <p>During an interview on 12/06/2023 at 11:25 AM, LVN #2 stated when a nurse administered medications, the nurse should check the medication one by one to ensure all medications were given as ordered. LVN #2 acknowledged he missed seeing the order for the fluticasone.</p> <p>During an interview on 12/06/2023 at 1:53 PM, the Assistant Director of Nursing stated when a nurse administered medications, the nurse should double, and triple check the electronic medication administration record (eMAR) with the medications prepared to ensure the right dosage, right resident, and right medication.</p> <p>During an interview on 12/06/2023 at 2:00 PM, the Director of Nursing (DON) stated when a nurse administered medications, the nurse should read the eMAR to look at the orders to ensure they had the right resident, right medication, right dose, and right time. The DON stated the nurse should double check the orders to ensure all ordered medications were administered to the resident.</p> <p>(continued on next page)</p>

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/06/2023 at 2:31 PM, the Administrator stated that he expected all medications to be given as ordered by the physician unless the medication was refused by the resident or other circumstances prevented the medication from being administered.		