STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056037	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Hills Manor	370 Noble Court Morgan Hill, CA 95037

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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44583

Based on interview, and record review, the facility failed to ensure one of three residents (Resident 1) received the necessary care and services when:

1a. The interdisciplinary team (IDT - a group of health care professionals from diverse fields who work toward a common goal for residents) did not develop a change in condition plan of care (POC) for Resident 1;

1b. There was no close monitoring of Resident 1 for signs and symptoms of hypoglycemia (low blood sugar level) and no documentation of hypoglycemia protocol in Resident 1's clinical record; and

1c. Licensed nurses did not follow Resident 1's physician order for post operative (post-op, aftercare assessment and treatment after a surgery) follow-up with the surgeon.

These failures had the potential to affect resident's care, health, and well-being.

Findings:

1a. Review of Resident 1's Admission Record dated 12/26/2023, indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including acute kidney failure (a sudden loss of kidney function), chronic metabolic acidosis (a condition in which there is too much acid in the body fluids), cystitis (swelling of the bladder [an organ that stores the urine secreted by the kidneys], usually caused by bladder infection), dysphagia (difficulty in swallowing) , and retention of urine (inability to empty all the urine from the bladder). Further review indicated, Resident 1 was discharged to hospital on 12/14/2023.

Review of Resident 1's Admission/5-day scheduled minimum data set (MDS, an assessment tool) dated 11/28/2023, indicated Resident 1's brief interview for mental status (BIMS, assessment for cognition level) score was 15 (13-15 score suggests the resident is cognitively intact).

Review of Resident 1's interim payment assessment (IPA, an optional MDS assessment when resident had experienced changes to his or her clinical condition) MDS, dated [DATE], indicated Resident 1's BIMS score was 03 (0-7 suggests severe cognitive impairment).

(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 - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with director of nursing (DON) on 12/26/2023 at 12:51 p.m., DON confirmed there was an IPA MDS assessment completed for Resident 1. DON stated they did the IPA MDS assessment because there was a decline in Resident 1's cognition and had intravenous infusion (or IV drip, administration of fluids or medicines straight to the resident's veins rather than having to swallow). DON confirmed the IDT did not address Resident 1's decline in cognition and there was no plan of care developed. During interview with certified nursing assistant A (CNA A) on 12/26/2023 at 1:46 p.m., CNA A confirmed she took care of Resident 1. CNA A stated Resident 1 was very confused when she was transferred out to the hospital. During an interview with MDS assistant (MDSA) on 5/10/2024 at 10:27 a.m., MDSA stated they did the IPA MDS assessment when there were some changes in resident's care and resident's condition. MDSA further stated IDT meeting should have been done first for MDS nurses to know if an IPA assessment was needed to be completed. MDSA confirmed there should have been a comprehensive plan of care to address the resident's decline. During a concurrent interview and record review on 5/10/2024 at 11:21 a.m., assistant director of nursing (ADON) reviewed Resident 1's clinical records. ADON confirmed Resident 1's changed in condition were as follows: critical blood glucose levels at 39-50 milligrams per deciliter (mg [unit of measurement]/ dL[unit of capacity]) (Normal range: 70-100 mg/dL) as indicated in Resident 1's progress notes dated 11/30, 12/13 and 12/14/2023; increased confusion as indicated in Resident 1's progress note dated 12/11/2023 and with increased word salad (a jumble of extremely incoherent speech), low blood pressure, mildly increased heart rate as indicated in the nurse practitioner's (NP) note dated 12/12/2023. Another review of NP's progress note dated 12/13/2023, ADON confirmed Resident 1 had mild expressive aphasia (a language disorder wherein the person is unable to communicate effectively to others). ADON stated Resident 1 was not admitted with aphasia. ADON confirmed she was a member of the IDT. ADON tried to look for the IDT notes in Resident 1's clinical records but did not find one. ADON confirmed IDT missed to review Resident 1's condition and they missed to develop a new plan of care. ADON stated there should have been an IDT meeting note to addressed Resident 1's decline, possible contributing factors, and developed plan of care. ADON further stated, they had a walking IDT where the team would make rounds and visited residents with change in condition. During a concurrent interview and record review on 5/10/2024 at 12:02 p.m., case manager (CM) reviewed Resident 1's clinical records. CM confirmed she was Resident 1's case manager and she was involved in the IDT. CM confirmed she did not find any documentation of the IDT's meeting notes and the POC to address Resident 1's decline.CM stated she was not even aware about Resident 1's changed in condition before Resident 1 was transferred out to the hospital. CM confirmed Resident 1 did not come back when transferred out. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, INTERDISCIPLINARY WALKING ROUNDS, dated in 2017, indicated, Walking Rounds are completed on a regularly scheduled basis to manage new admission transitions of care and to mitigate unnecessary transfers related to changes of condition. The results of such IDT efforts assist in both clinical and financial management by identifying changes and intervening more quickly. Additional positive outcomes would be anticipated: Improved resident/family satisfaction & decreased grievances due to enhanced communication and attention .Provide supportive documentation for the at-risk resident and for on-going observation of resident condition. IDT members see the resident through their own expertise, all at the same time, thereby developing a holistic picture of the resident, helping to define the most appropriate referrals and interventions .There are four types of IDT Walking Rounds .4. Clinical Change of Condition: Required meeting attendees: DON, ADON and/or nursing designee. Other IDT members as necessary. Based on SBAR [Situation, Background, Assessment and Recommendation, a documentation completed by nurses whenever there is a change in resident's condition] and/or other observations, the DON reviews clinical condition changes and decides whether a COC WR [change of condition walking rounds] is necessary (by next business day). This may include conditions such as .weight loss, change in behavior .worsening body systems concerns. 1b. Review of Resident 1's SBAR Communication Form and Progress Note for RNs [Registered Nurses] /LPN [also known as Licensed Vocational Nurses (LVNs)] /LVNs dated 11/29/2023, indicated Resident 1 had a critical low blood sugar level of 50mg/dL. Further review indicated, Faxed results to MD [medical doctor]. Pending response. Will endorse to AM [morning] Supervisor to F/U [follow up] with MD. There was no other documented assessment, or a repeat blood sugar checked, and no documented interventions performed to address Resident 1's critical low blood sugar level. Review of Resident 1's General Note dated 12/13/2023 at 12:52 a.m., indicated, Received update from lab [laboratory] with critical low value for glucose [blood sugar] of 44. Notified MD of critical value . Further review did not indicate further assessment, monitoring and other interventions to address Resident 1's critical low blood sugar. Review of Resident 1's General Note dated 12/14/2023 at 1:00 a.m., indicated, Received critical low glucose level of 39 .MD notified of critical low value and lab results faxed to MD. No new orders at this time. Further review did not indicate further assessment, monitoring and other interventions to address Resident 1's critical low blood sugar. During an interview with ADON on 12/26/2023 at 12:14 p.m., ADON stated nurses should have assessed Resident 1 for any signs and symptoms of hypoglycemia, checked her blood sugar again, initiated any possible interventions and then, notified the physician. ADON further stated, nurses should have monitored Resident 1 for any signs and symptoms of hypoglycemia. During an interview with licensed vocational nurse B (LVN B) on 12/26/2023 at 12:26 p.m., LVN B confirmed he was one of the nurses who took care of Resident 1 and LVN B was aware about Resident 1's critical low blood sugar level. LVN B stated, once they received a critical low blood sugar level, she should have assessed the resident for any signs and symptoms of hypoglycemia, they could re-check the blood sugar, offer orange juice if it was still low then notify the physician. LVN B further stated, they should have documented whatever interventions they did to the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with DON on 12/26/2023 at 12:51 p.m., DON stated nurses should have notified the physician right away, assessed resident and initiated an intervention to manage hypoglycemia. DON did not have a clear answer whether nurses should re-checked Resident 1's blood sugar level again after they received a critical low blood sugar level from the laboratory. During an interview with licensed vocational nurse C (LVN C) on 12/26/2023 at 1:30 p.m., LVN C confirmed Resident 1 was pretty much confused, when she took care of her. LVN C stated, they should assess the resident when they received resident's critical low blood sugar level, offered orange juice, if needed, and notified the physician. LVN C further stated, they should have manage intervention related to hypoglycemia provided to the resident. During a review of the facility's policy and procedure titled, Hypoglycemia Management, dated 11/2021, indicated, It is the policy of this facility to ensure effective management of a resident who experiences a hypoglycemic episode. The facility will identify residents that are at risk for hypoglycemia and observe them for signs and symptoms of low blood glucose. A bedside blood glucose test should be administered for any resident reporting or experiencing symptoms of hypoglycemia such as: .fast heart beat .confusion .weakness or having no energy. If the blood glucose reading is 70 mg/dL or below, the nurse will utilize the hypoglycemic protocol as per the practitioner's orders, with follow up blood glucoses as indicated, and notify the practitioner of the results as ordered. The blood sugar(s) and treatment will be documented as per facility protocol. 1c. Review of Resident 1's clinical records titled, Interfacility Transfer Report, dated 11/24/2023, indicated Resident 1 had a discharged order for a post op appointment with the general surgeon on 12/4/2023 at 2:15 p.m. Review of Resident 1's Order Summary Report, order dated 11/24/2023, indicated, a post op appointment with the general surgeon on 12/4/2023 at 2:15 p.m. During a phone interview with DON on 5/14/2024 at 3:32 p.m., DON confirmed Resident 1's post op appointment was not followed as ordered by the physician. DON stated, honestly speaking, I am not sure of what happened. DON confirmed there was no documentation that indicated Resident 1 made it to her appointment. DON stated, she interviewed the nurse who received the order and confirmed the physician's order was not properly transcribed to Resident 1's medication administration record (MAR). DON confirmed, the order was not in Resident 1's MAR that was why nobody knew about the appointment. DON further confirmed, their social services did not receive the appointment information for them to set up transportation. During a review of the facility's policy and procedure titled, PROCESSING PHYSICIAN ORDERS, dated August 2017, indicated, It is practice of this facility to process physician orders through entry into the Electronic Health Record (EHR) and to clarify these orders with the attending physician, including communication of any system identified medication contraindications prior to submission to the pharmacy. To verify and maintain accuracy of physician orders to provide appropriate care and services . Upon patient admission/readmission the LN [licensed nurse) enters the hospital transfer orders, obtained from the acute hospital discharge summary or discharge order sheet . All admission orders are reviewed the next business day by nursing management.