STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056388	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradise Valley Health Care	2575 E. Eighth St. National City, CA 91950

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on interview and record reviews the facility failed to ensure a care plan for Resident 1 ' s refusal of medications was developed and implemented. This failure had the potential for the care and interventions to not be communicated to all health care providers. Findings. A review of Resident 1 ' s dated Admission Record indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included Orthopedic Aftercare Following Surgical Amputation, Diabetes (abnormal blood sugar) with chronic kidney disease (failure of the kidneys to filter waste from the blood). An interview was conducted on 3/13/24 at 10:47 A.M., with certified nursing assistant (CNA) CNA 1 stated Resident 1 never complained of not having water at his bedside. An interview on 3/13/24 at 10:55 A.M., with licensed nurse (LN) LN 1 was conducted. LN 1 stated Resident 1 loved his snacks and enjoyed foods brought by his family when they visited. An interview on 3/13/24 at 11:10 A.M. with LN 2 was conducted. LN 2 stated Resident 1 never refused his snacks, blood sugars checks but Resident 1 was always concerned with it and his medications. On 3/13/24 at 11:30 A.M. with the Physical therapist (PT) was conducted. The PT stated Resident 1 was very impulsive and was very adamant on going back to his wheelchair from his bed during therapy sessions. The PT stated he had to remind Resident 1 not to bear weight on his bilateral lower extremities. A record review of Resident 1 ' s Physicians order summary report dated March 13, 24 indicated that Resident 1 had orders for the following medications : Gabapentin (medication for nerve pain) capsule (CAP) by mouth three times a day, Insulin Glargine(diabetic injection) 100 unit/m inject 40 units (unit of measurement)subcutaneously (SQ- under the skin) at bedtime, and tuberculin PPD solution (Tuberculosis test) given once intradermal under the (epidermis-layer of skin). (continued on next page)

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

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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	A record review of Resident 1 ' s nursing progress indicated that Resident 1 had episodes of refusing the medications on the following dates and times: Gabapentin three times a day on 2/22/24 and 2/26/24, tuberculin test on 2/22/24 insulin glargine at bedtime on 2/20/24, 2/22/24, 2/29/24, 3/3/24 and 3/5/24. A record review of Resident 1 ' s medication administration record (MAR) indicated that Resident 1 refused his Gabapentin on 2/22/24 and 2/26/24, tuberculin test on 2/22/24 and insulin glargine on 2/20/24, 2/22/24, 2/29/24, 3/3/24 and 3/5/24. A record review of Resident 1 ' s medical record indicate there was no care plan on Resident 1 ' s refusal of these medications and injections. An interview on 3/21/2024 at 10:50 A.M., with the assistant director of nursing (ADON) was conducted. The ADON stated the care plan on Resident1 ' s refusal of medications needed to be initiated, developed, and implemented. The ADON stated a care plan was important to make everyone aware of the care that their residents need, and it tells the story of how they took care of their residents, including Resident 1. A joint interview and record review on 3/21/2024 at 10:30 A.M., with the Director of Nursing (DON) was conducted. The DON stated there was no care plan of Resident 1 ' s refusals of medications and tuberculosis testing in Resident 1 ' s medical record. The DON stated there was poor documentation on the nurse ' s part. The DON stated a care plan was very important so that everyone was aware of the care being provided to Resident 1. A record review dated February 2021 of the facility ' s Policy and Procedure titled, Requesting, Refusing or Discontinuing Care or Treatment . #7. If the decision to refuse or discontinue treatment results in a significant change of condition, a reassessment will occur, and appropriate changes will be made to the resident ' s care plan. #8. Detailed information relating to the request, refusal or discontinuation of treatment are documented in the resident ' s medical record.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on interview and record reviews, the facility failed to ensure staff are competent in managing Resident 1 ' s Diabetes (a chronic [long lasting] health condition that affects how your body turns food into energy) when staff did not notify Resident 1 ' s medical doctor on his medication refusals. This failure had the potential to negatively affect Resident 1 ' s health condition and possible decline. Findings. A review of Resident 1 ' s dated Admission Record indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included Orthopedic Aftercare Following Surgical Amputation, Diabetes (abnormal blood sugar) with chronic kidney disease (failure of the kidneys to filter waste from the blood). An interview on 3/13/24 at 11:00 A.M., with licensed nurse (LN) LN 1 was conducted. LN stated Resident 1 had episodes of refusing his medications including his insulin (diabetic medication) and that they have explained to him it ' s risk and consequence for his actions. LN1 stated that the medical doctor (MD) notification was important so that the MD can adjust Resident 1 ' s medications if needed. A record review of Resident 1 ' s medication administration record (MAR) indicated that Resident 1 refused his Gabapentin (medication for nerve pain) on 2/22/24 and 2/26/24, tuberculin test (tuberculosis skin testing) on 2/22/24 and insulin glargine (diabetic medication) on 2/20/24, 2/22/24, 2/29/24, 3/3/24 and 3/5/24. A record review of Resident 1 ' s nursing progress indicated that Resident 1 had episodes of refusing the medications on the following dates and times without the MD notification. Gabapentin three times a day on 2/22/24 and 2/26/24, tuberculin test on 2/22/24 insulin glargine at bedtime on 2/20/24, 2/22/24, 2/29/24, 3/3/24 and 3/5/24. An interview on 3/21/24 at 10:43 AM., with the assistant director of nursing (ADON) was conducted. The ADON stated it was important for the nurses to notify Resident1 ' s MD regarding his refusals on his medications so Resident 1 ' s MD will make the decision to adjust Resident 1 ' s medications, either to lower or increase the dosage or discontinue the medication. The ADON stated Resident 1 ' s MD can also provide education to the nurses regarding managing Resident 1 ' s overall health condition. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/21/22 at 11:00A.M., with the Director of Nursing (DON) was conducted. The DON stated MD notification was important so that Resident 1 ' s MD was aware if the plan of care was not implemented regarding Resident 1 ' s episodes of medication refusals. A record review of the facility ' s policy titled, Change in a Resident ' s Condition or Status .Policy Interpretation and Implementation .#1 The nurse will notify the resident ' s his or her attending physician and the resident representative of changes in the resident ' s medical/mental condition and/or status .f. refusal of treatment or medications two (2) or more consecutive times .