STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056429	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Convalescent Hospital	7509 N Laurel Ave Fontana, CA 92336

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44262 Based on interview and record review the facility failed when the Licensed Vocational Nurse (LVN 1) failed to assess, notify the physician and the responsible party of a change of condition for one of three sampled residents (Resident 1) according to facility policy. This failure placed a clinically compromised Resident (Resident 1) health and safety at risk by causing a delay in treatment, and transfer to acute hospital for evaluation. Findings: During review of Residents 1's Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses to include: encephalopathy (brain disease causing declining concentration, memory loss, personality changes, sepsis (infection in bloodstream), type 2 diabetes mellitus (body does not make enough insulin or does not use insulin well), urinary tract infection (urine infection), hypertension (high blood pressure), hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side (paralysis to one side, partial weakness , conditions affection blood flow to the brain), osteoarthritis (wear down of bones), methicillin susceptible staphylococcus aureus infection MRSA (bacteria that's become resistant to many antibiotics used to treat infections). During a review concurrent interview and record review of Resident 1's Medical Record with the Intern Director of Nursing (DON) and Administrator, reviewed are as follows: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change of Condition (COC)Note dated April 04, 2024, at 1615: Blood sugar 44, Blood pressure 135/70, Pulse 62, respiration 17, 02 87%, 7:15AM received patient stable resting in bed head elevated 35-45-degree angle. Patient awake, alert and oriented. Able to talk and respond questions .730 received breakfast, 9AM patient received all medications BS 208 .insulin administered as ordered, inject 20 unit sub-q one time a day for Diabetes Mellitus (DM) replace Lantus .patient daughter call for info patient status and remind patient, answer the cell phone 12:30, Certified Nursing Assistant (CNA) report Patient is sleeping no respond feed, respiration even labored, no distress noted. 3:00PM Daughter and granddaughter came visit patient. 3:10PM Patient' Daughter report Patient does not respond as usual, and deep sleeping. 3:11 PM: Monitor patient oxygen (02) 84, Blood Sugar (BS) 44. immediately call 911, make doctor aware. given sugar and orange juice, 02/2 Liters. Reposition patient for comfort Patient awake respond the question. back to sleep. 3:15: Monitor BS 47, 02 86 give orange juice and sugar/ spoons, Patient awake and smile. back to sleep. encourage patient to stay awake. 3:20: monitor BS 42, orange juice and sugar/spoons 3:33 PM: Monitor BS 44 02 83 3:39: Glucagon (treats very low blood sugar) administer. Arrive First Responded Firefighters. 3:40: Emergency Medical Responder (EMR) Take over Patient. During an interview on May 01, 2024, with the Certified Nursing Assistant (CNA), the CNA stated, In the morning, Resident 1 seemed fine in the start of the day, during breakfast I sat her up, she is a feeder. She would take a bite and dose off and fall asleep. I did report to charge nurse, License Vocational Nurse (LVN 1), during breakfast time, I told her she's not staying awake to continue feeding her. She came in the room and took her vitals, Lunch time, I came back at to feed her, and she was doing the same as in the morning time, she wasn't eating not chewing or swallowing, I told (LVN 1) yet again. I actually had to put on gloves and remove the food in her mouth, I told her this is the same thing happening from breakfast time, I think she went to take vitals .the family came back at 3 PM, family closed the door, I heard them banging the bed and daughter came out saying she is not waking up , all the nurses came to the room with oxygen and they called 911. I only day I had her, I did notify the nurse, I reported it both times to the LVN. I didn't document, I should have taken the extra step to document. I would have written about her not staying awake, removed food from mouth and charge nurse made aware. There should have been documentation of this, but it was reported both times. I followed chain of command, reported to my LVN and then LVN reports to Registered Nursing (RN) supervisor. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on May 01, 2024, with the License Vocational Nurse (LVN 1), the LVN1 stated, I started rounds I checked Resident 1 orders, Blood sugar 208 in the morning, breakfast she was stable, she request pain medications for 7/10 pain, at 9:30 no pain noted. Around 10:30 daughter called on status on resident, that she kept calling the mom can you let her know I'm calling can she pick up the phone. I also sent info to the CNAs. Around 1230 lunch time CNAs said resident was sleeping with no respond feed, no distress noted. I checked her respirations and when I called for her, she opened eyes and went back to sleep. Around PM the daughter and granddaughter came to visit the resident, on time shift, at 3:10 resident was not responding was usual and deep sleeping. Immediate I went to the room [ROOM NUMBER]:11 . Blood Sugar 44, immediately we call 911, we called the doctor. She had episodes of awake and sleeping . she was in sitting 90-degree position, she was alert but fell back to sleep. They tried to encourage her to wake up. The CNA did not inform me about this resident not eating and being sleepy starting breakfast time. I was not informed that CNA had to extract food from her mouth because she was not eating or chewing due to her sleepiness. The CNA did not tell my anything about this. At 1230 the CNA said Resident 1 was sleepy, I checked on respirations I did not check vital signs, she responded to me when I called her, and she went back to sleep. He reported she was sleeping and no response feed. She would have periods of sleepy and awake; she was not awake all the time. She answered my commands. The CNA did not tell me any other conditions. I would have told my RN supervisor and go assist with vitals and blood sugar. For me in that moment, she did response in that moment. During an interview on May 01, 2024, and May 07, 2024, with the Director of Nursing DON (DON), the DON stated, Regarding the Change of Condition, yes, I can agree, there should have been a better assessment for this resident. There was a delay in treatment for this resident. There should be documentation for the blood sugar results. During an interview on May 01, 2024, and May 07, 2024, with the Administrator (Admin), the Admin stated, Based on the interview I heard with LVN1 regarding the Change of Condition, I can agree, there should have been a better assessment for this resident. There was a delay in treatment for this resident. During a review of the facility's policy and procedure titled, Change of Condition revised January 24, 2017, the policy and procedure indicated: To ensure proper assessment and follow-through for any resident with a change of condition .Definition: A change of condition is a sudden or marked difference in resident's: 3. Appetite .14. Level of consciousness, 15. Level of functioning. Content: A. All changes of condition in a resident shall be handled promptly.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44262 Based on interview and record review the facility failed to continually document blood sugar results in the medical record for one of three sampled residents (Resident 1). This failure placed a clinically compromised Resident (Resident 1's) health and safety at risk when the facility was not able to track blood sugar patterns and results. Findings: During review of Residents 1's Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses to include: encephalopathy (brain disease causing declining concentration, memory loss, personality changes, sepsis (infection in bloodstream), type 2 diabetes mellitus (body does not make enough insulin or does not use insulin well), urinary tract infection (urine infection), hypertension (high blood pressure), hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side (paralysis to one side, partial weakness , conditions affection blood flow to the brain), osteoarthritis (wear down of bones), methicillin susceptible staphylococcus aureus infection MRSA (bacteria that's become resistant to many antibiotics used to treat infections). During a review concurrent interview and record review of Resident 1's Medical Record with the Intern Director of Nursing (DON) and Administrator, reviewed are as follows: Medication Administration Record (MAR) March 2024 and April 2024: order fingerstick blood sugar check, every shift for Diabetes Mellitus, order date March 30, 2024. One touch ultra test strips four times a day for blood sugar before meals and bedtime order date March 28, 2024 1921. Order for Insulin Glargine-yfgn 100 unti/mL inject 20 Units subcutaneously daily . (No complete Documentation of blood sugar results in MAR or progress notes, no clarification of sliding scale). During an interview and record review of Resident 1's (MAR) for March 2024 and April 2024 on May 07, 2024, with the License Vocational Nurse (LVN 2), the LVN2 stated, For diabetes residents most of them have a sliding scale, they all have a sliding scale. We check the blood sugar in the MAR we put in the results, the number, in the MAR it lights up how many units. If we are not giving insulin because of the range, we document why we are not giving insulin as well. The results are usually on the MAR. You are not tracking the Blood Sugar if it's no documented. There should be another row in the MAR to document. There should be a sliding scale, I would clarify this order. Once resident is admitted and the fax is sent to the pharmacy, the medications are here within 4 hours from admission. During an interview on May 07, 2024, with the License Vocational Nurse (LVN 3), the LVN3 stated, Usually for all resident that have diabetes they have a sliding care, but I have seen some orders that don't have a sliding scale, just glucose checks. We still document the results, if there is no space in the MAR we document in progress notes. We have to document the results of the blood sugar check. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on May 01, 2024, and May 07, 2024, with the Registered Nurse Supervisor (RN), the RN stated, If resident is diabetic, we take initial Blood Sugar on admission and then follow the orders. The results should be recorded in the MAR, there should be documentation. You have to document the results and the ranges. There has to be a sliding scale with our Diabetic residents or clarify the orders. During an interview on May 01, 2024, and May 07, 2024, with the Director of Nursing DON (DON), the DON stated, When asked, why was there no documentation of blood sugar results? Stated, the order was imputing incorrectly, parameters were not added to the order. The RN supervisor also reviews the medications reconciliation for admitting residents. Resident 1 had blood sugar checks every shift. Some nurses were documenting in the progress notes, I seen two results and one in the COC. Reviewing the admitting orders page 8-9 start there is no sliding scale on admitting orders. Which is why she [admitting nurse] entered it and discontinued it in the same day. The admitting orders states to stop certain medications Humulin N NPH which has the sliding scale and continue with Insulin Glargine-yfgn. Regarding the documentation, yes, there should be documentation for the blood sugar results. During an interview on May 01, 2024, and May 07, 2024, with the Administrator (Admin), the Admin stated, There should be documentation for the blood sugar results and there is not, we cannot find it in the medical record for this resident. During a review of the facility's policy and procedure titled, Obtaining a Fingerstick Glucose Level revised October 2011, the policy and procedure indicated: The purpose of this procedure is to obtain a blood sample to determine the residents blood glucose level. Documentation 1 the nurse shall assess and document/report the following .b. Level of consciousness, change in orientation, c. dose and time of mist recent antihyperglycemic given .i. resident's blood sugar history over 48 hours, j. usual patterns (fluctuations, trends) of blood sugar over recent months .6. Documentation .6. The blood sugar results. During a review of the facility's policy and procedure titled, Charting and Documentation revised July 2017, the policy and procedure indicated: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44262 Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) received intravenous antibiotic medications as prescribed by the physician. This failure had placed a clinically compromised Resident (Resident 1) health and safety at risk by causing a delay in treatment when IV antibiotic medication were not given as ordered by a physician. Findings: During review of Residents 1's Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses to include: encephalopathy (brain disease causing declining concentration, memory loss, personality changes, sepsis (infection in bloodstream), type 2 diabetes mellitus (body does not make enough insulin or does not use insulin well), urinary tract infection (urine infection), hypertension (high blood pressure), hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side (paralysis to one side, partial weakness , conditions affection blood flow to the brain), osteoarthritis (wear down of bones), methicillin susceptible staphylococcus aureus infection MRSA (bacteria that's become resistant to many antibiotics used to treat infections). During a review concurrent interview and record review of Resident 1's Medical Record with the Intern Director of Nursing (DON) and Administrator, reviewed are as follows: Discharge Continue Medication list from [admitting hospital]: Page 2 of 9, Daptomycin 500mg in sodium Chloride 0.9% 50mL IVPB every 24 hours . Route Intravenous (IV) start March 18, 2024, Ertapenem Adapter Vial 1 gram (INVANZ) every 24 hours .IV route start March 11, 2024, page 10 .Plan for 6 weeks total of ertapenem 1 gram daily therapy March 11, 2024-Arpil 22, 2024, plan for 6 weeks total of daptomycin 8 mg/kg IV every 24 hours from fist negative blood culture March 13, 2024-April 24, 2024. Consolidated Deliver Sheets Pharmacy IVs Delivered March 30, 2024: Dapto 500mg/Normal saline 100 quantity 2. (Resident 1 admitted [DATE]). IV Medication Administration Record (MAR) March,2024; Daptomycin Chloride Intravenous Solution 500-0. 9mg/50mL% one time a day for negative blood culture until 04/24/24 23:59 Given at 1000 March 30, 2024. (Resident 1 admitted [DATE]). During an interview and record review on May 01, 2024, and May 07, 2024, with the Registered Nurse Supervisor (RN), the RN stated, We get inquire paperwork, from admitting hospital and I have to compare the medications and call the doctor. We take vitals and do full assessment. We enter the medication orders in our system and fax it to pharmacy, if any questions about the medications, I talk to nurse. When the orders are put in, its usually 4 hours when we get the medications in facility. We also have an E-kit (emergency medications kit) we can use. I talked to the Resident 1's daughter that day, we told her the medications were not here yet. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on May 01, 2024, and May 07, 2024, with the Director of Nursing DON (DON), the DON stated, Resident 1 was admitted [DATE], late evening, the following morning we sent her out March 29, 2024, because we did not have the IV medications in yet from pharmacy. The admitting nurse for that day is no longer here. The pharmacy does come in the evenings to provide medications. During an interview on May 01, 2024, and May 07, 2024, with the Administrator (Admin), the Admin stated, Resident 1 was sent out March 29, 2024, due to daughter request because the pharmacy had not sent over the IV antibiotics, she came back March 30, 2024, and the antibiotics were delivered that day. We did not have the IV medication to administer until March 30, 2024, but we did send her out to the hospital per daughter's request, we did everything for that situation. During a review of the facility's policy and procedure titled, Administering Medications revised April 2019, the policy and procedure indicated: Medications are administrated in a safe and timely manner and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame .7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified example, before and after meal orders.