

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056457	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Greenridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2150 Pyramid Drive El Sobrante, CA 94803	

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 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>45875</p> <p>Based on interviews and record review, the facility failed to ensure 1 of 3 sampled residents (Resident 1) received necessary care and services in accordance with professional standards of practice when Licensed Vocational Nurse (LVN) 1 did not re-assess and/or document Resident 1's vital signs (Vital signs reflect essential body functions, including heartbeat, breathing rate, temperature, and blood pressure and health care providers monitor vital signs to check patients' level of physical functioning) after a change in blood pressure (Blood pressure is the measurement of the pressure or force of blood inside your arteries. Each time heart beats, it pumps blood into arteries that carry blood throughout the body) and oxygen saturation (is the amount of oxygen you have circulating in your blood) values were noted significantly lower from Resident 1's baseline for more than 12 hours.</p> <p>This deficient practice placed Resident 1 at risk for delay in receiving higher level of care in a timely manner. Resident 1 was later transferred to the acute care hospital due to altered mental status and hyponatremia.</p> <p>Findings:</p> <p>1. During a record review of Resident 1's Admission Record, printed on 4/13/23, the Admission Record indicated Resident 1 was admitted to the facility in November 2022. The Admission Record indicated that Resident 1 had medical diagnoses including multiple fractures of the pelvis, urinary tract infection, and atrial fibrillation (Atrial fibrillation is an irregular and often very rapid heart rhythm).</p> <p>During an interview on 6/13/24 at 4:00 p.m. with Resident Representative (RR), RR stated on 11/22/22, when he visited Resident 1 at 7:30 p.m., she was very confused. RR stated he notified the charge nurse to assess Resident 1 and to send Resident 1 out to the hospital. RR stated Resident 1 was not sent to the hospital until 11/23/22 around 2 p.m.</p> <p>During a concurrent interview and record review on 6/19/24 at 12:43 p.m. with Registered Nurse (RN) 1, Resident 1's Progress Notes were reviewed. RN 1 stated on 11/23/22 in the morning, RR called the facility to check if Resident 1 was sent to the hospital. RN 1 stated she assessed Resident 1 and noted Resident 1 to be confused. RN 1 notified Nurse Practitioner (NP) and got orders for stat labs. RN 1 stated around lunch time Certified Nursing Assistant (CNA) reported Resident 1 was not responding well and appeared more confused and Resident 1 was sent to the hospital around 2 pm.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/19/24 at 1:10 p.m. with RN 1, Resident 1's Skilled services documentation and weights and vitals summary were reviewed. RN 1 stated on 11/22/22 Resident 1 's blood pressure (Normal range 120/80 mm hg- Systolic pressure reflects the force produced by the heart when it pumps blood out to the body, while diastolic blood pressure [the bottom number] is the pressure in your blood vessels when the heart is at rest) was documented as 97/58 mm Hg at 4:06 p.m. The document also indicated a triggered warning from the system that diastolic low of 60 exceeded. RN 1 stated Resident 1's blood pressure was lower than her baseline. RN 1 also stated the notes were documented by the morning shift, LVN 1.</p> <p>During a concurrent interview and record review on 6/19/24 at 1:15 p.m. with Registered Nurse 1, Resident 1's Skilled services documentation and weights and vitals Summary were reviewed. RN 1 stated on 11/22/22 Resident 1's oxygen saturation was documented as 90 % which is lower than her baseline. RN 1 stated Resident 1 did not have any underlying respiratory issue and an oxygen saturation reading of less than 93 % should be assessed. RN 1 stated a licensed nurse should have rechecked the vital signs and assessed the resident after a few minutes to ensure the vital sign numbers were correct and should have documented the findings. RN 1 also stated the next vital signs were documented on 11/23/22 at 7:55 a.m., which was more than 15 hours after noticing a change in Resident 1's vital signs from her baseline values.</p> <p>During a concurrent interview and record review on 6/19/24 at 3:35 p.m. with Director of Nursing (DON), Resident 1's diagnosis and progress notes were reviewed. DON stated Resident 1's systolic blood pressure is very low. DON also stated Resident 1 does not have any respiratory conditions and her oxygen saturation is 90%. DON stated the licensed nurse should have rechecked and compared the vital signs and documented the findings. DON also stated it is important to recheck because if the vital signs are persistently abnormal, they must notify the Physician.</p> <p>During an interview on 6/20/24 at 10:10 a.m. with NP, NP stated if there are changes to vital signs, staff should check if the vital signs are co-relating to resident's baseline. NP also stated staff should recheck and re-assess the resident and monitor every 30 minutes to ensure resident is stable.</p> <p>During an interview on 7/1/24 at 4:19 p.m. with LVN 1, LVN 1 stated she does not remember working with Resident 1. LVN 1 stated if there was a change in vital signs from a resident's baseline, she would recheck the whole set of vital signs again and document the rechecked vital signs. LVN 1 stated if any changes in condition or vitals are noted, it should be reported and followed up on.</p> <p>During a record review of Resident'1, Emergency Department Notes from the acute care hospital, dated 11/23/22, the Emergency Department Notes indicated Resident 1 was admitted to the Emergency Department with an altered mental status and hyponatremia (low sodium level in the blood and can cause mental confusion, seizures, coma, and death). Resident 1's sodium was 124 with normal range 136-144.</p> <p>During a review of the facility ' s policy and procedures (P&P) titled, Change in a Resident's Condition or Status, revised in May 2017, the P&P indicated, Procedure .3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR communication form 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p>		