

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2024
NAME OF PROVIDER OR SUPPLIER  Arlington Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3688 Nye Avenue Riverside, CA 92505	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240</b></p> <p>Based on observation, interview and record review, the facility failed to ensure for one of four residents, Resident 9, had the call light button within his reach. This failure had the potential to result in Resident 9 not being able to call for help.</p> <p>Findings:</p> <p>On April 17, 2024, at 9:15 a.m., an unannounced visit was conducted at the facility to investigate a complaint allegation.</p> <p>On April 17, 2024, at 9:56 a.m., an observation with a concurrent interview was conducted with Resident 9. Resident 9 was lying in bed, alert and conversant. Resident 9's call light button was observed on the floor on the right side of the bed. Resident 9's call light button was not within his reach. Resident 9 stated his call light was usually near him.</p> <p>On April 17, 2024, at 10:01 a.m., an observation with a concurrent interview was conducted with the Licensed Vocational Nurse (LVN). The LVN stated Resident 9's call light button was on the floor. The LVN stated, the call light button should be within Resident 9's reach. The LVN further stated, Resident 9 will not be able to ask for help if his call light was on the floor.</p> <p>A review of Resident 9's records was conducted. Resident 9 was admitted to the facility on [DATE], with diagnoses which included dementia (a set of symptoms that can affect memory, language, and behavior), hypertension (high blood pressure), diabetes mellitus (high blood sugar level) and muscle weakness. The Minimum Data Set (MDS - an assessment tool) dated April 13, 2024, indicated Resident 9 had severe cognitive impairment. The care plan dated April 9, 2024, indicated Resident 9 had alteration in musculoskeletal (muscles and bones) status related to muscle weakness and abnormalities of gait (manner of walking) and mobility (ability to move). The care plan further indicated . be sure call light is within reach .</p> <p>On April 17, 2024, an interview was conducted with the Director of Nursing (DON). The DON stated Resident 9 would not be able to ask for help when his call light was on the floor.</p> <p>A review of the facility's policy and procedure titled, Answering the Call Light, dated October 2010 was reviewed. The facility indicated .when the resident is in bed or confined to a chair be sure call light is within easy reach of the resident .</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 056485	If continuation sheet Page 1 of 5

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48240</p> <p>Based on interview and record review, the facility failed to initiate and provide notices of proposed transfer/discharge (NOPD- a form that will indicate the notification of resident and reason for transfer/discharge) to three out of 4 residents, Resident 4, 5, and 7 and/or their responsible parties. In addition, the facility failed to notify the Long-Term Care Ombudsman (an advocate for residents and families in long-term care facilities) of Residents 4, 5, and 7's transfer/discharge from the facility.</p> <p>These failures had the potential for Residents 4, 5, and 7 to be unable to reach the Ombudsman. In addition, these failures caused the Ombudsman the inability to ensure Residents 4, 5 and 7 rights were protected.</p> <p>Findings:</p> <p>On April 15, 2024, at 9:55 a.m., an unannounced visit was conducted at the facility.</p> <p>A record review of Resident 4's record was conducted. Resident 4 was admitted to the facility on [DATE], with the diagnoses which included stroke (a loss of blood flow to part of the brain), diabetes mellitus type 2 (high blood sugar) and heart failure (heart muscle doesn't pump blood as well as it should). Resident 4 was transferred out to the hospital on March 22, 2024, for shortness of breath. There was no documented evidence that an NOPD was initiated, and that the Ombudsman was notified of Resident 4's transfer to the hospital.</p> <p>A record review of Resident 5's record was conducted. Resident 5 was admitted to the facility on [DATE], with diagnoses which included heart failure, atrial fibrillation (rapid and irregular heart rhythm) and hyperlipidemia (high cholesterol level). Resident 5 was discharged home on March 29, 2024. The NOPD was initiated but was incomplete. There was no documented evidence that the Ombudsman was notified of Resident 5's discharge to home.</p> <p>A record review of Resident 7's record was conducted. Resident 7 was admitted to the facility on [DATE], with diagnoses which included epilepsy (a brain condition that causes recurring seizures - uncontrolled electrical activity), hypertension (high blood pressure), and osteoporosis (bones become fragile and more likely to break). Resident 5 was discharged to home on April 12, 2024. There was no documented evidence that an NOPD was initiated, and that the Ombudsman was notified.</p> <p>On April 15, 2024, at 12:22 p.m., an interview with the Social Service and record review of Residents 4, 5, and 7's records were conducted. Resident 4's records were reviewed. The SSD stated Resident 4 was transferred out to the hospital on March 22, 2024, for shortness of breath. The SSD stated the NOPD was not initiated and provided to the resident. The SSD further stated that the Ombudsman was not notified as well because the NOPD was not initiated.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 5's records were reviewed. The SSD stated Resident 5 was discharged to home on March 29, 2024. The SSD stated the facility initiated Resident 5's discharge. The SSD stated the NOPD was incomplete, and she was not sure what was given to Resident 5. The SSD further stated the NOPD should have been completed. In addition, the SSD stated the Ombudsman was not notified of Resident 5's discharge.</p> <p>Resident 7's records were reviewed. The SSD stated Resident 7 was discharged to home on April 12, 2024. The SSD stated the NOPD was not initiated and provided to the resident. The SSD stated the Ombudsman was not notified because the NOPD was never initiated.</p> <p>The SSD further stated, she sent the NOPDs to the Ombudsman weekly, on Fridays, via fax (facsimile, a form of electronic communication).</p> <p>On April 15, 2024, at 2:12 p.m., a concurrent interview with the Director of Nursing and record review of Resident 4, 5 and 7's records were conducted. A review of Resident 4's records were reviewed. The DON stated there should have been an NOPD and the SSD should have followed up. The NOPD should have been sent right after Resident 4 left the facility.</p> <p>A review of Resident 5's records were conducted. The DON stated the facility initiated Resident 5's discharge. The DON stated the SSD should have completed the NOPD.</p> <p>A review of Resident 7's records were conducted. The DON stated the facility initiated Resident 7's discharge. The DON stated the NOPD should have been initiated and provided to the resident/ responsible party on April 11, 2024.</p> <p>The DON further stated, it was important to send the NOPDs to the Ombudsman so that the Ombudsman will be able to follow up with them.</p> <p>On April 15, 2024, at 3:46 p.m., a follow up interview was conducted with the SSD. The SSD stated she did not send any NOPDs to the Ombudsman on April 12, 2024, because she had sent some on April 9, 2024. The SSD stated she waits until there were sufficient discharges before sending the NOPDs to the Ombudsman. The SSD stated NOPDs should be provided to the resident or responsible party as soon as a discharge date has been established.</p> <p>A review of the facility document titled, Notice of Proposed Discharge Log, dated April 9, 2024, indicated there was a total of 18 residents discharged from the facility between March 19, 2024, and April 9, 2024. Residents 4 and 5 were not included on the facility document. The facility document further indicated that NOPDs were faxed to the Ombudsman on April 9, 2024.</p> <p>A review of the facility's policy and procedure titled Transfer or Discharge Notice, dated March 2021, was reviewed. The policy indicated .the resident and representative are notified in writing of the following information: a. the specific reason for the transfer or discharge; b. the effective date of the transfer or discharge; c. the location to which the resident is being transferred or discharged .a copy of the notice is sent to the Office of the State-Long Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative .</p>

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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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48240</p> <p>Based on interview and record review, the facility failed to ensure that, for one of two residents, Resident 8, follow-up appointments with a cardiologist (a physician who is an expert in the care of the heart) and pulmonologist (a physician who is an expert in the care of the lungs) were scheduled. This failure had the potential to result in Resident 8 to have delayed treatments and additional increased risk of health complications.</p> <p>Findings:</p> <p>On April 17, 2024, at 9:15 a.m., an unannounced visit was conducted at the facility for an investigation of a complaint allegation.</p> <p>On April 17, 2024, at 9:40 a.m., an observation with a concurrent interview was conducted with Resident 8. Resident 8 was lying in bed, alert and conversant. Resident 8 stated she was concerned about her cardiology (study of the heart) appointment. Resident 8 stated she, her brother and sister-in-law had reached out to the Social Service Designee (SSD) about the status of her cardiology appointment. Resident 8 stated, she nor her brother had not heard from the SSD. Resident 8 stated she had a very low blood pressure a few days ago and staff informed her physician. Resident 8 further stated, she was newly diagnosed with atrial fibrillation (irregular and rapid heart rhythm), and she was now required to wear a (cardiac) life vest (a wearable electric shock machine that can stop an abnormal heart rhythm).</p> <p>A review of Resident 8's records were reviewed. Resident 8 was admitted to the facility on [DATE], with diagnoses which included myocardial infarction (heart attack), heart failure (heart muscle does not pump blood as well as it should), atrial fibrillation and acute respiratory failure (lungs cannot release enough oxygen into your blood).</p> <p>The Order Summary Report, dated April 17, 2024, indicated the following:</p> <p>. F/U (follow up) with (name of doctor) / Cardiology # (phone number) .Order Date 3/30/2024 (March 30, 2024) .</p> <p>.F/U with (name of doctor) in 1-2 (one to two) weeks # (phone number) .Order Date 03/30/2024 .</p> <p>On April 17, 2024, at 11:25 a.m., an interview with a concurrent record review of Resident 8's physician's orders were conducted with the Licensed Vocational Nurse (LVN). The LVN stated Resident 8 had a physician's order on March 30, 2024, to follow up with (name of doctor) and (name of doctor). The LVN stated it had been more than two weeks since these were ordered. The LVN stated she was not aware if these had been scheduled. The LVN stated she was not aware if Resident 8 had gone for any doctor's appointments. The LVN further stated it was the responsibility of the SSD and Case Manager (CM) to schedule residents' appointments.</p> <p>(continued on next page)</p>		

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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>On April 17, 2024, at 11: 56 a.m., an interview was conducted with the SSD. The SSD stated, she and the CM were responsible for scheduling doctors' appointments including transportation. The SSD stated nurses will leave a note for her when there are physician's orders to follow up with another doctor. The SSD also stated she and CM sent referrals and requested for authorizations if needed. The SSD stated Resident 8 had a physician;s order to follow up with cardiology for her (cardiac) life vest. The SSD stated she had sent referrals and was still waiting for a call. The SSD stated Resident 8 had a physcian's order to follow up with another doctor which was a pulmonologist. The SSD stated Resident 8's follow-up appointments had not been scheduled. The SSD stated There was no urgency to schedule the cardiology appointment. The pulmonology (study of the lungs) appointment should have been scheduled in one to two weeks from when it was ordered. The SSD further stated she should have sent more referrals and made multiple phone calls to get appointments for Resident 8.</p> <p>On April 9, 2024, at 12:30 p.m., an interview with the CM was conducted. The CM stated she scheduled some doctor's appointments for the residents in the facility. The CM stated she was aware Resident 8 needed cardiology and pulmonology appointments. The CM stated she was assigned to schedule the pulmonology appointment. The CM stated she had called the pulmonologist's phone number, but she did not have a clinic, that Resident 8 can be redirected to another pulmonologist, and she was asked to send a referral. The CM stated she was still waiting on a response. The CM stated she did not document when she reached out to the pulmonologist. The CM further stated, There was no urgency to schedule the pulmonology appointment.</p> <p>On April 9, 2024, at 2:05 p.m., an interview with the Director of Nursing (DON) with a concurrent record review of Resident 8's physician's orders were conducted. The DON stated, the SSD and CM scheduled the residents' appointments including transportation. The DON stated it had been 17 days since Resident 8 had the physician orders to follow up with a cardiologist and a pulmonologist. The DON stated Resident 8 was on (cardiac) life vest and it was important for her to be seen by a cardiologist.</p> <p>On April 9, 2024, at 3:42 p.m., a follow up interview with the DON was conducted. The DON stated the facility's policy did not indicate a timeframe for scheduling residents' doctor's appointments. The DON further stated, There was no urgency to schedule the appointments for Resident 8.</p> <p>On April 9, 2024, at 4:40 p.m., a follow up interview with the CM and record review of Resident 8's progress notes were conducted. The CM stated there was no documented evidence that Resident 8's physician was notified when they were having difficulty in scheduling her cardiology and pulmonology appointments.</p> <p>A review of the facility's policy and procedure titled, Referrals, Consults, dated December 2008 was reviewed. The policy indicated .social services or designee shall coordinate resident referrals .referrals for medical services must be based on physician evaluation of resident need and a related physician order . social services or designee will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician .staff will document the referral in the resident's medical record .</p>		