

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2024
NAME OF PROVIDER OR SUPPLIER  Arbor Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1200 Springfield Drive Chico, CA 95928	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755</b></p> <p>Based on interview and record review, the facility failed to directly involve one of 22 sampled residents (Resident 1), and their Responsible Party (RP, a person designated to make decisions on behalf of a resident) in a treatment decision, when the RP was not notified of, and a consent for an Ear, Nose and Throat (ENT) consult was not obtained prior to treatment. This failure resulted in Resident 1 receiving treatment by an ENT that the RP was not informed of and did not approve of.</p> <p>Findings:</p> <p>A review of the facility policy titled Resident Rights revised February 2021, indicated, Employees shall treat all resident with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: p. be informed of, and participate in, his or her care planning and treatment.</p> <p>A review of Resident 1's, undated, Admission Record indicated Resident 1 was admitted on [DATE] with diagnoses including dementia, muscle weakness, dysphagia (difficulty in swallowing), anxiety, and depression.</p> <p>A review of Resident 1's physician orders, dated 5/1/24, indicted Resident 1 did not have the capacity to understand choices, to make health care decisions and/or participate in treatment plan. An RP was identified.</p> <p>A review of Resident 1's Consent to Treat dated 4/14/23, and signed by the RP, indicated The Resident hereby consents to routine nursing services or emergency care as rendered by Facility under the general and specific instruction [an order] of Resident physician</p> <p>During an interview on 5/31/24 at 1:34 pm, the RP said she received a bill from Medicare for the service date of 3/22/24 for services from an ENT for Resident 1. The RP indicated she knew nothing about this visit and did not give consent for this.</p> <p>During an interview with the Social Service Assistant (SSA) A on 5/31/24 at 3:25 pm, the ENT Appointment List dated March 22, 2024, for ENT services was reviewed. SSA A confirmed that Resident 1 was on the list to be seen by the ENT consultant for that day. SSA A indicated, Resident 1 should not have been on this list because the RP did not want Resident 1 to be seen by any consulting physicians. SSA A stated, Everyone here knows that, and it is written in her chart. SSA A looked through Resident 1's chart and was unable to find any documentation concerning this.</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's ENT Nurse Practitioner's (NP) notes, for the visit on 3/22/24, indicated Resident 1 had cerumen (wax) removed from both ears, a nasal endoscopy (thin flexible or rigid tube with a tiny camera and light that is inserted into the nose and guided through the nasal and sinus passages) and laryngoscopy (a rigid tube with a tiny camera and light that is inserted into the mouth and throat to examine the throat and voice box, larynx).</p> <p>During an interview on 5/31/24 at 4:00 pm, SSA B confirmed she oversaw the ENT visits. SSA B confirmed that Resident 1 was seen by the ENT and that she had not notified the RP about the visit and that should not have happened. SSA B stated she was unaware that Resident 1 was going to be seen and she was unsure how Resident 1 got on the list to be seen.</p> <p>During an interview and record review with the Social Service Director (SSD) on 5/31/24 at 4:15 pm, Resident 1's orders were reviewed. SSD confirmed that Resident 1 had no orders for an ENT consult in her chart. SSD confirmed Resident 1 was treated by the ENT NP without an order, RP notification or consent and this should not have happened. The SSD indicated she had no idea that this resident had been seen.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43755</p> <p>Based on interview, and record review the facility failed to maintain complete and accurately documented medical records in accordance with accepted professional standard for 1 of 1 sampled residents (Resident 1) when:</p> <ol style="list-style-type: none"> <li>1. Resident 1 had a change of condition and medication was ordered by the physician but there were no nurses notes describing the condition of Resident 1.</li> <li>2. An Ear Nose and Throat Practitioner (ENT, an outside provider) did rounds in the facility and saw Resident 1 and no documentation of the visit were in the residents' medical record.</li> </ol> <p>These failures had the potential to prevent accurate information for Resident 1 regarding medical care and condition to be available to the residents, their representatives and other care providers.</p> <p>Findings:</p> <p>A review of the facility's policy titled Charting and Documentation dated July 2017, indicated 2. The following information is to be documented in the resident medical record: a. Objective observations. b. Medications administered. c. Treatments or services performed. d. Changes in the resident's condition</p> <p>1.A review of Resident 1's, undated, Admission Record indicated Resident 1 was admitted on [DATE] with diagnoses including dementia, muscle weakness, dysphagia (difficulty in swallowing), anxiety, and depression.</p> <p>A review of Resident 1's physician orders written on 12/8/23, indicated Resident 1 did not have the capacity to understand choices, to make health care decisions and/or participate in treatment plan. A Responsible Party (RP, a person designated to make decisions on behalf of a resident) with) was identified.</p> <p>During an interview with Resident 1's RP on 6/4/24 at 3:21 pm, the RP indicated she had been notified by a nurse that a physician had ordered medications for Resident 1, but the RP was unable to get information about what the treatment was for.</p> <p>During an interview with the Assistant Director of Nursing (ADON), and a record review on 6/5/24 at 2:42 pm, Resident 1's physician orders and nurses notes were reviewed. The ADON confirmed an order for Resident 1, dated 6/4/24 , consisting of medications including, DuoNeb's (a breathing treatment that helps with breathing), Mucinex (a medication to thin mucus), and a Z-Pac (an antibiotic to treat infections). A review of the nurse's notes revealed there was no documentation of Resident 1's condition for 6/4/24. The ADON indicated this was a condition change for Resident 1 and there should have been a Change of Condition charting done and there was not. The ADON did not know why it had not been done or why these medications were ordered.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Licensed Nurse (LN) A and record review on 6/5/24 at 3:09 pm, a Physician's Communication Form dated 6/4/24, concerning Resident 1 by LN A was reviewed. The form indicated a brief description of Resident 1's condition including Resident continues to cough producing yellow sputum (mucus that is coughed up from the lower airways) , sats (oxygen saturation in the blood,) in the low 90's, afebrile (without fever), family very concerned. Please Assess. The physician ordered DuoNeb's bid (twice a day) times 2 weeks then prn (as needed), Mucinex 400 mg (milligrams) bid and a Z-Pac for 5 days. LN A confirmed she had not documented Resident 1's condition in the nurse's notes and did not do a change of condition for this resident and she should have.</p> <p>2. During an interview on 5/31/24 at 1:34 pm, Resident 1's RP indicated she had called the facility about medical records for an ENT visit Resident 1 had on 3/22/24. RP indicated that the Social Service Director (SSD) told her there were no records in the chart about an ENT visit and that they did not know Resident 1 had been seen.</p> <p>During an interview with the SSD on 6/5/24 at 12:30 pm, the SSD confirmed that the facility did not have any documentation of an Ear Nose and Throat consult on 3/22/24 for Resident 1, and the 20 other residents seen that day, until 5/29/24 (two months after the appointment). The SSD said, we did not realize that we did not have the documented visits and we should have.</p>		