

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/02/2024
NAME OF PROVIDER OR SUPPLIER  Blythe Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 285 West Chanslor Way Blythe, CA 92225	

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>50122</p> <p>Based on interview and record review, the facility failed to coordinate cardiology specialty (specialty doctor that treats conditions related to the heart) care for one of three sampled residents (Resident 3), after a new diagnosis of atrial fibrillation (an irregular and often very rapid heart rhythm) on May 4, 2024.</p> <p>This failure had the potential to result in worsening cardiac (heart) function, stroke (occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts), and/or other serious medical complications.</p> <p>Findings:</p> <p>During an interview on July 1, 2024, at 12:05 p.m., with Resident 3, Resident 3 stated she was diagnosed with atrial fibrillation during a recent admission to the hospital several weeks ago. Resident 3 stated it was a new diagnosis that she never had before. Resident 3 stated about a week after she returned to the facility, she asked the DON (Director of Nursing) to notify the physician about the need to follow up with cardiology. Resident 3 stated she reminded the DON again last week of the need for an appointment with cardiology but has not been informed of any appointments with cardiology as of July 1, 2024.</p> <p>On July 1, 2024, Resident 3's record was reviewed. A review of Resident 3's Licensed Nurses Progress Notes, indicated the following:</p> <ul style="list-style-type: none"> <li>- Dated April 29, 2024, . Resident is noted to be confused &amp; (and) altered from baseline .for transfer to (name of the hospital) .</li> <li>- Dated May 4, 2024, .returned to (name of skilled nursing facility) .</li> </ul> <p>A review of Resident 3's Discharge Documentation/Instructions, from acute hospital, dated May 4, 2024, indicated Resident 3 had a diagnosis of atrial fibrillation with RVR [rapid ventricular (lower chambers of the heart, to beat too fast) response].</p> <p>Further review of Resident 3's Progress Notes, from May 4, 2024 to July 1, 2024, indicated, there was no documentation Resident 3 was seen by cardiology.</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 an interview and record review with the DON on July 1, 2024, at 1:55 p.m., the DON stated, the facility physician (FP) saw Resident 3 two days after the hospital discharge. The DON stated on May 4, 2024, the FP ordered Eliquis (apixaban - used to prevent serious blood clots from forming due to a certain irregular heartbeat, such as atrial fibrillation) 5 milligram orally twice daily. The DON stated the only follow up care listed on discharge instructions was with primary care physician.</p> <p>During an interview and record review on July 1, 2024, at 4:05 p.m. with the FP, the FP stated, he could not recall if he ordered an appointment with cardiology for Resident 3, or if an order was written for follow up. The FP stated he did write an order for Eliquis on 5/4/2024. The FP stated the licensed nurses should have followed up with him. The FP stated if Resident 3 was having symptoms, Resident 3 should have been seen sooner to address what was going on with her. The FP stated he was not aware Resident 3 had not seen a cardiology. The FP stated with a new diagnosis of atrial fibrillation, Resident 3 should have been seen by cardiology within 1 month of discharge from acute hospital.</p> <p>During a review of the policy and procedure titled, Physician Visits , revised April 2013, states that .the attending physician will visit residents in a timely fashion .depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems .The attending physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation.</p> <p>During a review of the policy titled Change in a Resident's Condition or Status , revised May 2017, states . Facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status .the nurse will notify the resident's attending physician on call when there has been a .significant change in the resident's physical/emotional/mental condition; need to alter the resident's medical treatment significantly .specific instruction to notify the physician of changes in the resident's condition . If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations .</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36038</p> <p>Based on interview and record review, the facility failed to ensure for two of four sampled residents (Residents 1 and 3), were free of significant medication error when the prescribed Augmentin (amoxicillin and potassium clavulanate - drug used to treat bacterial infections in many different parts of the body (ear, lungs, sinus, skin, urinary tract) was not administered on three occasions for Resident 1 and on two occasions for Resident 3.</p> <p>This failure had the potential to worsen both residents' infections, leading to prolonged illness and discomfort.</p> <p>Findings:</p> <p>On June 8, 2024, at 11:50 a.m., an unannounced visit to the facility was conducted to investigate a quality of care and treatment issue.</p> <p>1. During an interview on June 8, 2024, at 1:26 p.m., with Resident 1, she stated it takes three days for her to receive Augmentin. Resident 1 stated last night (June 7, 2024), she did not receive her antibiotics because the facility ran out. Resident 1 further stated the antibiotics would not be effective in killing germs if the body is a log gap between doses. Resident 1 stated the antibiotics should be given on time, as scheduled.</p> <p>During a review of Resident 1's admission record, indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD- a respiratory problem).</p> <p>A review of Resident 1's Physician's order dated June 6, 2024, indicated, .Augmentin Oral Tablet 500- 125 MG (milligram- unit of measurement) (Amoxicillin &amp; Pot clavulanate) Give 1 tablet by mouth every 8 hours for cough and congestion for 7 days .</p> <p>A review of Resident 1's Nurses Medication Notes, for the month of June 2024, indicated Resident 1 was not administered with Augmentin for the following dates and times:</p> <p>a. On June 6, 2024, at 10 p.m., .Augmentin .unavailable awaiting from pharmacy .</p> <p>b. On June 7, 2024, at 6 a.m., .Augmentin .awaiting delivery from pharmacy .</p> <p>c. On June 7, 2024, at 10 p.m., .Augmentin .no med (medication) available .</p> <p>During a concurrent interview and review of Resident 1's Medication Administration Record for the month of June 2024, was conducted with Licensed Vocational Nurse (LVN) 1, on June 24, 2024, at 2:16 p.m. LVN 1 stated when the initials of the LVN were circled on the MAR, it meant that the medication was not given. LVN 1 stated Resident 1 was not administered Augmentin on the night of June 6, 2024, and twice on June 7, 2024.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. A review of Resident 3's admission record indicated, Resident 3 was admitted to the facility on [DATE], with diagnoses which included diabetes (high blood sugar) and urinary tract infection (UTI-kidney or bladder infection).</p> <p>A review of Resident 3's Physician's Order, dated June 4, 2024, at 18:54 (6:54 p.m.) indicated, .Augmentin Oral Tablet 500- 125 MG (Amoxycillin &amp; Pot clavulanate) Give 1 tablet by mouth three times a day for UTI for 10 days .</p> <p>A review of Resident 3's Nurses Medication Notes, for the month of June 2024, indicated, the following:</p> <p>a. June 6, 2024, at 12 p.m., Amoxicillin-Clavulanate .out of med (medication) .</p> <p>b. June 6, 2024, at 10 p.m., Amoxicillin-Pot (potassium) Clavulanate .unavailable awaiting from pharmacy .</p> <p>During a concurrent interview and review of Resident 3's Medication Administration Record for the month of June 2024, with LVN 1, on June 24, 2024, at 2:16 p.m., LVN 1 stated when the initials of the licensed nurse were circled on the MAR, it indicated Augmentin was not administered. LVN 1 stated the medication Augmentin was not available and awaiting delivery by the pharmacy. LVN 1 stated, it should have been given within two hours.</p> <p>During an interview on June 24, 2024, at 3:55 p.m., with the Pharmacist, she stated the drugs were taken by the driver at 1: 45 p.m., on June 7, 2024, and delivered to the facility at 11:16 p.m. The Pharmacist further stated the staff should have pulled the antibiotic from the e-kit (emergency kit) while waiting for the delivery.</p> <p>During an interview on June 24, 2024, at 4:03 p.m., with the Registered Nurse (RN), she stated the Augmentin should have been administered within 2 hours from the time it was ordered. The staff should have retrieved the drug from the E-kit.</p> <p>During an interview on July 1, 2024, at 10:50 a.m., with the Director of Nursing (DON), the DON stated if the E-kit does not contain the needed medication, the licensed nurse should notify the physician and/or obtain a new order or an order to wait for the required medication. The DON stated E-kits are supposed to be replenished within 48 hours. The DON further stated if the E-kits are not replenished, they should notify the pharmacy. The DON further stated the licensed nurse who opens the E-kit or is responsible for passing the medication when it is unavailable is the one who should contact the pharmacy for a replacement.</p> <p>During a review of facility policy and procedure, titled Administering Medications, dated April 2019, indicated . Medications are administered in accordance with prescriber order, including any required time frame . Medication are administered within one hour of their prescribed time .If a drug is withheld, .refused or given at a time other than the scheduled time .the individual administering the medication shall initial and circle in the MAR space .</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of facility policy and procedure, titled Emergency Medications, dated April 2007, indicated . The emergency medication kit will include medications .that are essential in providing emergency treatment . Medication and supplies used from the emergency medication kit must be replaced upon the next routine drug order .</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50122</p> <p>Based on observation, interview, and record review, the facility failed to ensure the diet order was followed according to the physician's order, for two of three sampled residents (Residents 2 and 3), when Residents 2 and 3 did not receive lemon pound cake on lunch meal tray on 7/1/2024 according to the diet ordered by the physician.</p> <p>These failures had the potential to result in compromising Resident 2 and 3's nutritional and medical condition.</p> <p>Findings:</p> <p>1. On July 1, 2024, at 12:30 p.m., a concurrent meal tray observation and review of Resident 2's Meal Tray Card, on July 1, 2024, were conducted. Resident 2 was observed being served cheesecake with cherry topping.</p> <p>A review of Resident 2's ADMISSION RECORD, printed July 1, 2024, indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus (a disease in which the pancreas does not produce enough insulin [a hormone that regulates the movement of sugar into the cells] and cells respond poorly to insulin and take in less sugar).</p> <p>A review of the Resident 2's Physician's order, dated May 1, 2024, indicated, NAS (no added salt), LCS (Low Concentrated Sweets), Puree (cooked food that has been ground, pressed, blended to the consistency of a creamy paste or liquid).</p> <p>A review of the Resident 2's Resident Diet Order History, dated May 1, 2024, indicated, NAS (no added salt), LCS (Low Concentrated Sweets - avoiding foods with a lot of sugar).</p> <p>A review of Resident 2's Lunch Meal Tray Card (menu based on the resident's diet physician order), indicated, No concentrated sweets, no added salt, puree.</p> <p>A review of the facility Spreadsheet, indicated, .Consistent carbohydrate (terminology use for no concentrated sweets) .Lemon Pound Cake .</p> <p>On July 1, 2024, at 4:10 p.m., a concurrent interview and review of Resident 2's diet order, dietary spreadsheet, and physicians order were conducted with the Dietary Supervisor (DM). The DM stated the physician had ordered a low concentrated sweets, puree, and no added salt diet for Resident 2. After reviewing the food items served to Resident 2 on July 1, 2024, the DM stated Resident 2 did not receive the correct dessert on the lunch meal tray. The DM stated the dietary staff should follow the diet spreadsheet and physicians order providing what was specified for a carbohydrate-restricted diet. The DM stated the dessert given on July 1, 2024, for Resident 2 was incorrect and Resident 2 should have received the lemon pound cake.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On July 1, 2024, at 4:30 p.m., a concurrent interview and review of Resident 2's physician diet order were conducted with the Director of Nursing (DON). The DON stated Resident 2 had a diet order for low concentrated sweets, no added salt, and a pureed diet. The DON stated the dietary department should have followed the orders as written by the physician.</p> <p>During a review of the facility policy and procedure (P&amp;P) titled Nursing Care of the Resident with Diabetes Mellitus , revised April 2011, the P&amp;P indicated, .the purpose of this guideline is .To help the resident control his/her diabetes with diet, exercise, and insulin .</p> <p>During a review of the policy titled Therapeutic Diet , revised October 2017, the P&amp;P indicated Therapeutic diets are prescribed by the Attending Physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences A ' therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: .Diabetic/calorie controlled diet .</p> <p>2. On July 1, 2024, at 12:30 p.m., a concurrent meal observation, interview, and review of Resident 2's Meal Tray Card, were conducted with Resident 3 in Resident 3's room. Resident 3 was observed being served cheesecake with cherry topping. Resident 3 stated she this is what I normally receive on my meal tray. Resident 3 stated they give me regular desserts all the time and I have told them.</p> <p>A review of Resident 3's ADMISSION RECORD, printed July 1, 2024, indicated, Resident 3 was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus.</p> <p>During a review of the facility document titled, Resident Diet Order History, dated July 1, 2024, indicated, Resident 3 is on a NAS, mechanical soft, LCS diet.</p> <p>A review of Resident 3's Lunch Meal Tray Card indicated, Mechanical soft, No concentrated sweets . No indication of NAS observed on meal tray card.</p> <p>On July 1, 2024, at 4:10 p.m., a concurrent interview and review of the physician diet order were conducted with the DM. She stated the physician had ordered LCS, NAS, Mechanical soft diet on June 10, 2022. After reviewing the lunch meal tray food items served on July 1, 2024, the DM admitted Resident 3 should not have received cheesecake with cherry topping and should have received lemon pound cake as indicated on the dietary spreadsheet for July 1, 2024. The DM stated the dietary staff should have followed the diet spreadsheet and physicians order, providing what was specified for a carbohydrate-restricted diet. The DM stated the dessert given for Resident 3 was incorrect.</p> <p>On July 1, 2024, at 4:30 p.m., a concurrent interview and review of Resident 3 meal tray image and Lunch Meal Tray Card were conducted with the DON. After reviewing the lunch meal tray being served to Resident 3 on July 1, 2024, and the meal tray card, the DON stated Resident 3 should have received lemon pound cake. The DON stated the dietary staff should have followed the physician order. The DON stated she was unaware that the residents were receiving the wrong items.</p> <p>During a review of the facility provided spreadsheet listed, Diet Extensions: Monday Week 2, Menu Press Cycle 1, 2024 by US Foods, dated December 7, 2023, indicated .Lunch .Consistent Carbohydrate/Regular .0. 5 (2x3 square) Lemon Pound Cake . Listed under Regular/Regular menu on same spreadsheet, has 1 slice of cheesecake with cherry topping .</p>		