Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555383	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blythe Post Acute LLC	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145 Based on interview and record review, the facility failed to develop a care plan (Identified healthcare conditions, including individualized goals and interventions) addressing the use of an illegal drug (marijuana- mind-altering [psychoactive] drug) while at the facility, for two of three sampled residents (Residents 1 and 2). This failure has the potential to result in mismanagement of resident's medical health issues for Resident 1 and 2. Findings: On October 30, 2024, at 11:40 a.m., an unannounced visit was made to the facility for a quality-of-care issue. On October 30, 2024, at 1:45 p.m., an interview was conducted with the Maintenance Supervisor (MS), who stated, on October 25, 2024, at approximately 4:00 p.m., she witnessed Resident 1 outside, who stated, I feel weird, like I'm having a stroke. The MS stated, she assisted Resident 1 into the facility and notified the nursing staff. A review of Resident 1's admission records undated, indicated the resident was admitted to the facility on [DATE], with diagnoses which included embolism (a vascular clot) and thrombosis (blood clot). A review of Resident 1's Minimum Data Set (an assessment tool) indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a cognitive assessment) score of 15 (no cognitive impairment). On October 30, 2024, at 3:26 p.m., during an interview, Registered Nurse (RN) 1 stated on October 25, 2024, she overheard Resident 1 stating she used marijuana and felt like she was having a stroke. RN 1 stated she did not initiate a care plan to address use of marijuana and the resident's feeling of having a stroke. A review of Resident 1's care plans did not indicate a care plan was developed to address alleged use of an illegal drug. (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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 31, 2024, at 1:40 p.m., a concurrent interview with the Director of Nursing (DON), and review of Resident 1's care plans was conducted. The DON stated, it is the responsibility of the charge nurse to initiate a care plan when a change of condition occurred. The DON verified on October 25, 2024, the charge nurse did not initiate a care plan for Resident 1's marijuana use, to include interventions of monitoring for the resident's safety. 2. A review of Resident 2's admission record, undated, indicated, the resident was admitted to the facility on [DATE], with diagnoses which included asthma (a lung disease that affects normal breathing). Further review of Resident 2's Minimum Data Set (an assessment tool) indicated Resident 2 had a BIMS score of 15. A review of Resident 2's progress notes, dated October 26, 2024, at 4:15 p.m., indicated, . (Resident 2) sitting in wheelchair with head slumped down unresponsive to verbal stimuli, unresponsive to sternal rub (hard knuckle rub on chest to illicit a response) .911 called . (Resident 2) awaken . (Licensed Vocational Nurse [LVN] 1) asked (Resident 2) if she was smoking (Marijuana) outside . (Resident 2) did not answer . (Medical Transport) arrived and (LVN 1) . gave report to . (Medical Transport Personnel [MTP]) . (MTP reported to LVN 1, Resident 2) admitted to (MTP) she did smoke (marijuana). (Resident 2 transferred) to (general acute care hospital [GACH] for evaluation) . On October 30, 2024, at 4:15 p.m., an interview was conducted with LVN 1, who stated it is the duty of the charge nurse to assess and monitor residents for safety, and initiate care plans. LVN 1 stated on October 26, 2024, she was the charge nurse, and at approximately 4:20 p.m., she was notified by nursing staff that Resident 2 was outside in her wheelchair, unresponsive, and 911 was called to send resident to GACH for further evaluation. A review of Resident 2's GACH laboratory results dated [DATE], at 5:30 p.m., indicated, a positive drug screen for marijuana use. Further review of Resident 2's care plans indicated; a care plan had not been initiated to address the use of marijuana. On October 31, 2024, at 1:40 p.m., a concurrent interview and review of Resident 2's care plans were conducted with the DON. The DON stated, a care plan should be updated or initiated, by nursing staff, or herself, when a new condition is discovered. The DON reviewed Resident 2's care plans and verified there was no care plan for positive marijuana use, after being confirmed via drug screen at the GACH. The DON stated care plan should have been initiated to ensure monitoring for adverse effects. The DON stated a care plan should have been initiated for the use of marijuana. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy and procedures, titled, Care Plans, Comprehensive, dated, December 2016, indicated, . A Comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 6. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Incorporated identified problem areas; c. Incorporate risk factors associated with identified problems; d. Reflect treatment goal, timetables and objectives in measurable outcomes; e. Identify the professional services that are responsible for each element of care; 7. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). 8. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .

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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** 46145 Based on interview and record review, the facility failed to assess and monitor the change in condition for one of two residents (Resident 1). This failure had the potential to delay necessary treatment for Resident 1. Findings: On October 30, 2024, at 1:45 p.m., an interview was conducted with the Maintenance Supervisor (MS), who stated, on October 25, 2024, at approximately 4:00 p.m., she heard Resident 1 saying she felt weird and felt like she was having a stroke. The MS stated, she assisted Resident 1 into the facility and notified nursing staff. A review of Resident 1's admission record, undated, indicated, resident was admitted to the facility on [DATE], with diagnoses which included embolism (a vascular clot) and thrombosis (blood clot). A review of Resident 1's Minimum Data Set (an assessment tool) dated July 20, 2024, indicated Resident 1 had a Brief Interview for Mental Status (a cognitive assessment) score of 15 (cognitively intact). On October 30, 2024, at 3:26 p.m., an interview was conducted with Registered Nurse (RN) 1, who stated, when a resident had a change of condition; she would assess, notify the physician, monitor the resident, and update or initiate the care plan. RN 1 stated on October 25, 2024, the MS assisted Resident 1 into the lobby. RN 1 stated Resident 1 told RN 2 she felt weird, as if she was having a stroke and she had smoked marijuana outside. RN 1 stated Resident 1 had a change of condition and should have been monitored. RN 1 further stated, she did not follow-up or monitor Resident 1. A review of Resident 1's progress notes, dated October 25, 2024, indicated no documentation reflecting Resident 1 was monitored and followed-up regarding the use of marijuana. A review of Resident 1's medical records, dated, October 25, 2024, indicated no documentation, such as a progress note, or COC, indicating the resident used marijuana, and experiencing feelings of having a stroke. A review of Resident 1's Care Plans indicated that no care plans were initiated for marijuana use or the reported symptoms of having a stroke. On October 31, 2024, at 9:40 a.m., an interview was conducted with RN 1, who verified, she was the only RN/Charge Nurse, scheduled to work the day of October 25, 2024. RN 1 stated RN 2 had come to draw blood (laboratories) on the residents and deliver the lab work to the outside laboratory. RN 1 verified, she did not follow-up with RN 2, regarding Resident 1's change of condition on October 25, 2024, to ensure monitoring interventions, documentation, and physician's instructions were completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 31, 2024, at 1:40 p.m., a concurrent interview and review of Resident 1's progress notes were conducted with the Director of Nursing (DON). The DON stated, she was not aware of the incident on October 25, 2024, involving Resident 1's use of marijuana and change of condition, as it had not been reported to her. The DON further stated, the charge nurse should be assessing the resident, notifying the physician for orders and instructions, initiating COC documentation, including 72 hours of monitoring, and updating the resident's care plan. The DON further stated, the charge nurse should have initiated the change of condition process for Resident 1 right away, as it would have been safer for the resident. The DON further stated, when a resident complained of having a stroke the protocol was to transfer the resident to acute hospital for further evaluation. A facility Policy & Procedure, titled, Change of Condition, revised, May 2017, indicated, . Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status . 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): a. accident or incident involving a resident; d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; g. need to transfer the resident to a hospital/treatment center; i. specific instruction to notify the physician of changes in the resident's condition. 2. A significant change of condition is a major decline or improvement in the resident's status . a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions . b. Impacts more than one area of the resident's health status; 3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provide, including (for example) information prompted by the SBAR (COC) 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 .