STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555435	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reche Canyon Regional Rehab Center	1350 Reche Canyon Rd Colton, CA 92324

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49231 Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for one of three residents (Resident 1), when the Registered Nurses failed to perform a comprehensive nursing assessment (a detailed physical examination of the patient's entire body, to gather information about the patient's status) on Resident 1 upon his initial admission to the facility on [DATE], and his readmission from the hospital on [DATE],after Resident 1 was sent out due to being unresponsive. This failure resulted in Registered Nurse 6 (RN 6) being unaware of Resident 1's paracentesis drainage tube (a catheter to remove fluid from the abdominal cavity) and connecting the enteral feeding formula (liquid food designed to provide nutrition directly into the stomach) to the paracentesis drainage tube, instead of the gastrostomy tube feeding (G-tube, a tube inserted through the abdominal wall that brings nutrition directly to the stomach). The administration of the enteral feeding formula into the peritoneal cavity (space within the abdomen that contains the intestines, the stomach and the liver) caused Resident 1 to experience unnecessary abdominal pain from the retained enteral feeding formula into the peritoneal cavity Resident 1 was transferred to a general acute care hospital (GACH) in the intensive care unit (ICU), where he died . Findings: During a review of Resident 1's Admission Record (contains demographic information), the Admission Record indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included, cardiac arrest (when a person's heart stop pumping blood around the body), end stage renal disease (condition in which kidneys can no longer function adequately to meet the body needs) with hemodialysis (a treatment to filter wastes and water from the blood), liver cirrhosis (condition in which liver is permanently damaged), diabetes mellitus type 2 (a condition in which pancreas can't produce enough insulin), tracheostomy status (a surgically created hole in the front of the neck and into the windpipe, to allow to insert a tube to keep it open for breathing) and gastrostomy status (a surgically that creates an opening in the stomach through the abdomen, allowing for a tube to be inserted and used for feeding). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's document [NAME], Facility: [name of the facility] . History and Physical (H&P-information about a patient's health status and to establish diagnosis), for Resident 1, dated [DATE], the H&P indicated Resident 1 had diagnoses which included, tracheostomy dependence, ventilator dependence (a machine that pumps air into the lungs when a patient is unable to breathe independently), dependence on renal dialysis (a treatment to filter wastes and water from the blood), paracentesis with peritoneal drain placement (peritoneal drainage tube) and gastrostomy tube dependent. During a concurrent interview and record review on [DATE], at 9:15 AM, with the Director of Nursing (DON), Resident 1's Admit/Readmit Screener V.2 (screener assessment - a basic health assessment), effective [DATE], at 2:01 AM, was reviewed. The Admit/Readmit Screener V.2 indicated, Resident 1 had a PEG-TUBE (PEG - percutaneous endoscopic gastrostomy tube inserted surgically through the abdomen into the stomach), received nutrition via tube feeding and received oxygen via tracheostomy. The Admit/Readmit Screener V.2, did not include Resident 1 had a paracentesis drainage tube and it was signed by License Vocational Nurse 7 (LVN 7). The DON was not able to provide documented evidence of a Registered Nurse conducted Resident 1's comprehensive assessment upon admission on [DATE], and readmission from the hospital, on [DATE]. The DON stated, LVN 7 completed the screener assessment, not a comprehensive assessment. During a review of Resident 1's nursing Progress Notes . Type: Alert Note, dated [DATE], at 2:26 AM, the Progress Notes indicated, @ [at] 0145 [1:45 AM] Family at bedside stated pt [patient] having difficulty breathing. RT [respiratory therapist] notified and performed interventions. Pt [Resident 1] observed unresponsive to verbal and tactile stimuli. Respirations observed, pulses palpable. Patient bagged at 100 % FiO2 [fraction of inspired oxygen - the percentage of oxygen in the air a person is breathing] via ambu-bag [a bag valve mask used to force air into the lungs of a person who cannot breathe] and regained consciousness . @ 0210 [2:10 AM] RT responded to mechanical ventilator alarm. Pt unable to respond appropriately. Pt was removed from ventilator and bagged again by RT. Rapid response called. Pt noted having 3 episodes of vomiting. RT suctioned copious amount of chunky secretions from tracheostomy tube and suspected patient may have aspirated. RN supervisor called 911 to send patient to ER for further evaluation . The Progress Notes . Type: Alert Note, was signed by Registered Nurse 2 (RN 2). During a review of Resident 1's nursing Progress Notes . Type: Admission Summary, dated [DATE] at 2:00 PM, the Progress Notes indicated, Resident returned from [name of the GACH] ER [emergency room] via gurney and [Name of ambulance] transport, without incident or injury, no new orders noted at this time from ER visit, resting in bed, no s/s [signs or symptoms] of distress to note, patient's wife at bedside, charge nurse aware, call light within reach, cooling measures implemented, all needs met by staff, will continue to monitor, bed in lowest position. The Progress Notes . Type: Admission Summary, was signed by the Subacute Manager/LVN (SM). During a review of Resident 1's nursing Progress Notes . Type: Transfer to Hospital Summary, dated [DATE], at 10:06 PM, the Progress Notes indicated, Wife asked CN [charge nurse] to connect drainage bag to paracentesis tube. When assessing the pt [patient] CN noted that the LTAD [Long Term Abdominal Drain] did not have the proper connection to connect the drain. CN noted that the tube appeared to have thick viscus cream/tan colored liquid in it. Informed RN supervisor to assess the resident. After assessment RN called NP [Nurse Practitioner] at 2045 [8:45 PM] and informed him of the situation. NP gave order to send patient out for further evaluation . The Progress Notes . Type: Transfer to Hospital Summary, was signed by Licensed Vocational Nurse 5 (LVN 5). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 9:55 AM, with the DON, the DON stated, she received a call from Registered Nurse 2 (RN 2) on [DATE], at approximately 10:00 PM, informing her that Resident 1's wife reported her husband complained of abdominal pain. The DON stated, RN 2 noticed the enteral feeding formula was infusing through Resident 1's paracentesis drainage tube. The DON further stated Resident 1 was transferred to GACH on [DATE], at 1:45 AM due to difficulty breathing and returned to the facility at 2:00 PM, on the same day. The DON stated, it was Registered Nurse 6 (RN 6)'s responsibility to assess Resident 1 upon his return from GACH and connect the enteral feeding formula to the G-tube, but she did not. During an interview on [DATE], at 11:35 AM, with Registered Nurse 2 (RN 2), RN 2 stated, on [DATE], at approximately 8:20 PM, Resident 1's wife reported her husband was having abdominal pain. The RN 2 stated, she assessed Resident 1 and observed the enteral feeding formula was infusing through the paracentesis drainage tube, which was on the floor. RN 2 further stated, she removed the feeding from the paracentesis drainage tube and called the physician. During an interview on [DATE], at 3:00 PM, with Registered Nurse 1 (RN 1), RN 1 stated, she saw Resident 1 in his room, on [DATE], at 3:30 PM, when she [RN 1] was doing rounds. RN 1 stated, she did not conduct a comprehensive nursing assessment to Resident 1. RN 1 further stated she should have performed it to Resident 1, after he [Resident 1] returned from the hospital. During a follow up interview on [DATE], at 3:20 PM, with the DON, the DON stated, when residents are admitted or readmitted from GACH, the license vocational nurse who admits the residents, perform Admit/Readmit Screener (a basic health assessment), not a comprehensive nursing assessment. The DON further stated, Registered Nurses are expected to complete a comprehensive nursing assessment within 24 hours of admission. During an interview and record review on [DATE], at 4:23 PM, with the Subacute Manager (SM), Resident 1's medical records were reviewed. The SM was not able to find documented evidence that demonstrate a comprehensive nursing assessment was performed to Resident 1. The SM stated, there was no documented evidence to indicate a comprehensive nursing assessment was conducted for Resident 1 upon his admission on [DATE], and readmission on [DATE]. During a concurrent interview and record review on [DATE], at 9:15 PM, with the DON, the DON reviewed Resident 1's medical records and was unable to find documented evidence that a comprehensive nursing assessment was performed for Resident 1 after his admission on [DATE], and his re-admission on [DATE]. During a concurrent interview and record review on [DATE], at 9:48 PM, with the DON, the facility's policy and procedure (P&P), titled, Admission Evaluation/Assessment & Follow Up: Role of Nurse, revised [DATE], was reviewed. The P&P indicated, The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission or readmission for the purpose of managing the resident, initiating the care plan and completing the required assessment instruments . The DON stated, the P&P did not indicate the staff responsible to perform the assessment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 9:58 PM with Registered Nurse 3 (RN 3), RN 3 stated it is the responsibility of the Registered Nurses to perform a comprehensive nursing assessment to the residents upon an admission or readmission to the facility. The RN 3 further stated the registered nurses would have 24 hours to complete a comprehensive nursing assessment and would need to endorse to the next shift if unable to complete a comprehensive assessment during admission. The RN 3 stated, the admission assessment must be documented in the residents' medical records. During a record review of the Registered Nurse job description, undated, the job description indicated, .4. Collect resident pre-admission and/or admission information and assist Director of Nursing Service to determine appropriate level of care . 19. Assess resident upon admission/readmission, change of condition, resident equipment, and supply needs, and make recommendations to the DON. An Immediate jeopardy (IJ- a situation in which an entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment, or death) was called on [DATE], at 10:15 PM under CFR 483.12(a)(1) Freedom from abuse, neglect, and exploitation. It was determined that due to the Registered Nurses lack of awareness, they failed to perform a comprehensive assessment to meet the needs of Resident 1, upon admission, on [DATE], and on readmission on [DATE], and resulted in Resident 1 being transferred out to GACH, in the intensive care unit (ICU). The IJ was called in the presence of Administrator and DON. A corrective Action Plan (CAP- a plan which includes interventions to remove the potential or actual harm of an immediate jeopardy situation) was requested. The Administrator provided CAP on [DATE], at 7:17 PM, the CAP was reviewed and approved on [DATE], at 11:35 AM, and included the following: 1) In-Service was conducted by the DON and Assistant director of Nursing (ADON), on [DATE], and completed on [DATE], regarding new admissions and readmissions to be assessed by RN upon admission/arrival to include head to toe assessment as soon as practically possible or within the first 2 hours from the time of admissions to assess stability of the resident, with documented evidence of full assessment by the end of the shift and according to the regulatory standards. 2) In-Service was conducted by the DON and ADON, on [DATE], and completed on [DATE], regarding Licensed staff including RNs will be educated by DON or Designee on the assessment process to ensure compliance prior to starting shifts. Ongoing training will be provided via verbal education and skills-check to existing and new staff, as needed and upon orientation, respectively, to ensure compliance. Onboarding Licensed staff and staff who are away will also be oriented of the proper procedures, with documented evidence accordingly, prior to beginning shift/ floor duties. 3) In-Service was conducted by the DON and ADON on [DATE], and completed on [DATE], regarding the policy and procedures of Admission Evaluation / Assessment & Follow-up: Role of Nurse. During a record review of three (3) residents (Resident 4, 5 and 6) admitted on [DATE], the comprehensive nursing assessment was performed by a Registered Nurse, within two (2) hours of admission. The acceptable CAP was verified with the facility through observations, interviews, and record review. The IJ was removed on [DATE], at 8:00 PM, in the presence of the Administrator and DON. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a record review of the hospital H&P, dated [DATE], the H&P indicated Resident 1 .presents w [with]/ 1d [one day] severe, constant, diffuse abdominal pain after received tube feeds though the peritoneal drain instead of his PEG tube [Percutaneous endoscopic gastrostomy - a feeding tube inserted through the skin and the stomach wall directly to the stomach]. MICU [Medical Intensive Care Unit] consulted d/t [due to] septic shock [when an infection causes dangerously low blood pressure and organ failure] ,d+[DATE] [secondary to] peritonitis [inflammation of the peritoneum, the thin tissue lining in the abdominal wall that covers the abdominal organs] in a trach [tracheostomy] dependent patient. During a record review of the hospital discharge summary, dated [DATE], the discharge summary indicated, . Continue on abx [antibiotic] and bedside washout (a procedure that involved washing the peritoneal cavity with a saltwater solution) performed by surgery team . family opting for non-surgical management given patient's overall clinical status at this time. Patient's family opting for comfort-focused care given grave prognosis [a prediction about the course of a disease]. He [Resident 1] passed surrounding by family.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49231 Based on observation, interviews, and record review, the facility failed to ensure licensed nurses were provided training to demonstrate competencies with paracentesis drainage tube (a catheter to remove fluid from the abdominal cavity) and gastrostomy tube feeding (G-tube, a tube inserted through the abdominal wall that brings nutrition directly to the stomach), for one of three residents (Resident 1) when Registered Nurse 6 (RN 6) connected and infused the enteral feeding formula (liquid food designed to provide nutrition directly into the stomach) to the paracentesis drainage tube, instead of the gastrostomy tube feeding, on [DATE]. This failure resulted in Resident 1 to experience unnecessary abdominal pain, retained enteral feeding formula into the peritoneal cavity (space within the abdomen that is lined by the peritoneum, a thin, smooth membrane) and Resident 1 was transferred to a general acute care hospital (GACH) in the intensive care unit (ICU), where he died . Findings: During a review of Resident 1's Admission Record (contains demographic information), the Admission Record indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included, cardiac arrest (when a person's heart stop pumping blood around the body), end stage renal disease (condition in which kidneys can no longer function adequately to meet the body needs) with hemodialysis (a treatment to filter wastes and water from the blood), liver cirrhosis (condition in which liver is permanently damaged), diabetes mellitus type 2 (a condition in which pancreas cannot 't produce enough insulin- a hormone that lowers the glucose in the blood), tracheostomy status (an artificial opening into the windpipe, that allows to insert a tube into the trachea, allowing a person to breathe) and gastrostomy status (a surgically created opening into the abdominal wall through which liquid nutrition and medication can be administered into the stomach). During a review of Resident 1's document titled, Facility: [name of the facility] . History and Physical (H&P-information about a patient's health status and to establish diagnosis), for Resident 1, dated [DATE], the H&P indicated Resident 1 had diagnoses which included, tracheostomy dependence, ventilator dependence (a machine that pumps air into the lungs when a patient is unable to breath independently), dependence on renal dialysis (a treatment to filter wastes and water from the blood), paracentesis with peritoneal drain placement (peritoneal drainage tube) and gastrostomy tube dependent. During a review of Resident 1's nursing Progress Notes . Type: Transfer to Hospital Summary, dated [DATE], at 10:06 PM, the Progress Notes indicated, Wife asked CN [charge nurse] to connect drainage bag to paracentesis tube. When assessing the pt [patient] CN noted that the LTAD [Long Term Abdominal Drain] did not have the proper connection to connect the drain. CN noted that the tube appeared to have thick viscus cream/tan colored liquid in it. Informed RN supervisor to assess the resident. After assessment RN called NP [Nurse Practitioner] at 2045 [8:45 PM] and informed him of the situation. NP gave order to send patient out for further evaluation . The Progress Notes . Type: Transfer to Hospital Summary, was signed by Licensed Vocational Nurse 5 (LVN 5). (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 9:20 AM, with License Vocational Nurse 1 (LVN 1). LVN 1 stated training and education was done regarding drainage tube in general, but not specifically on how to manage paracentesis drainage tube. During an interview and record review on [DATE], at 9:55 AM, with the Director of Nursing (DON), the DON stated Registered Nurse (RN 6) reported to her she [RN 6] hung Resident 1's enteral feeding and was unaware of the paracentesis drainage tube. The DON further stated, she contacted Resident 1's wife for a follow-up and was informed Resident 1 was in ICU and 200 mL (mL - milliliters, unit of measurement) of fluid was removed from the peritoneal cavity. During an interview on [DATE], at 10:37 AM, with License Vocational Nurse 2 (LVN2), LVN 2 stated he received education on how to check residual and placement of a gastrostomy tube feeding but could not differentiate between a gastrostomy tube feeding and a paracentesis drainage tube. During an interview on [DATE], at 11:03 AM, with Registered Nurse 1 (RN 1), RN 1 stated she received training for gastrotomy tube feeding, but was not familiar with the management of paracentesis drainage tube. During an interview on [DATE], at 11:35 AM, with Registered Nurse 2 (RN 2), RN 2 stated, on [DATE], at approximately 8:20 PM, Resident 1's wife reported her husband was having abdominal pain. The RN 2 stated, she assessed Resident 1 and observed the enteral feeding formula was infusing through the paracentesis drainage tube, which was on the floor. RN 2 further stated, she removed the feeding from the paracentesis drainage tube and called the physician. RN 2 stated she did not receive training or education for management of paracentesis drainage tube. During a concurrent interview and record review on [DATE], at 2:45 PM, with the DON, the facility's policy and procedure (P&P), titled, Managing Draining Tube, revised [DATE], was reviewed. The P&P indicated, Purpose . To Ensure safe Monitoring of drainage tubes such as JP [Jackson Pratt - a thin flexible tube with a bulb at the end that drains fluid away from a wound] Drains, Nephrostomy [a tube that lets urine drain from the kidney through an opening in the skin on the back], Urostomy [an opening in the abdomen that directs urine from the bladder], Paracentesis, G-Tube, etc. 1. All personnel responsible for monitoring drainage tubes will be trained, qualified and competent in his or her responsibilities . Preventing misconnection errors . 1. Assess all drainage tubes prior to treatment. 2. Regularly inspect tubing for proper and secure connections. The DON stated staff did not follow the policy. The DON further stated that education and training was conducted after the incident on [DATE]. The DON stated no training or education was done regarding paracentesis draining tube, prior to the incident. During a review of the facility's P&P titled, Competency of Nursing Staff, revised [DATE], the P&P indicated, 1. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. 2. In addition, licensed nursed and nursing assistants employed (or contracted) by the facility will: a. participate in a facility-specific, competency-based staff development and training program; and b. demonstrate specific competencies and skills sets deemed necessary to care for the needs of the residents, as identified through resident assessments and described in the plans of care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Immediate jeopardy (IJ- a situation in which an entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment, or death) was called on [DATE], at 10:15 PM under CFR 483.35(a)(3) Nursing Service. It was determined that nursing staff did not have competencies to take care Resident 1's paracentesis drainage tube and gastrostomy tube feeding. The IJ was called in the presence of Administrator and the DON. A corrective Action Plan (CAP- a plan which includes interventions to remove the potential or actual harm of an immediate jeopardy situation) was requested. The facility's Administrator provided CAP on [DATE], the CAP was reviewed and approved on [DATE], at 11:35 AM, included the following: 1) In-service initiated/conducted by Director of Nursing from [DATE], and completed on [DATE], on: a. Proper Infusion of G-Tubes and management of drainage tubes including, but not limited to paracentesis drainage tubes, b. Monitoring of the G-tube feeding by license staff per shift, to verify pump has been infused properly, c. Observe the status of the resident, and ensure resident's needs are met, d. As safety precaution 2 nurses will check to verify g-tube feedings for accuracy and compliance at the change of shift. e. Ongoing education and competency training to be provided to staff to verify competency of the licensed staff particularly as it relates to proper infusion and monitoring of G-tube feeding and managing paracentesis drainage tubes. f. Onboarding Licensed staff and staff who are away will also be oriented of the proper procedures, with documented evidence accordingly, prior to beginning shift/ floor duties. 2) In-service initiated/conducted by DON and Assistant Director of Nurses (ADON) from [DATE], and completed on [DATE], regarding identifying the different type of enteral feeding, enteral tube use and maintenance, tube occlusion: Prevention/Management, g-tube replacement, and patency. During an observation on [DATE], at 7:30 PM, during shift change (AM shift- PM shift). Incoming and outgoing staff, shift report at the bedside of each patient, verifying the gastrostomy tube feedings site, patency [flushing with water], the correct formula and feeding pump settings. The acceptable CAP was verified with the facility through interview and record review. The IJ was removed on [DATE], at 8:00 PM, in the presence of the Administrator and DON. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a record review of the hospital H&P, dated [DATE], the H&P indicated Resident 1 .presents w [with]/ 1d [one day] severe, constant, diffuse abdominal pain after received tube feeds though the peritoneal drain instead of his PEG tube [Percutaneous endoscopic gastrostomy - a feeding tube inserted through the skin and the stomach wall directly to the stomach]. MICU [Medical Intensive Care Unit] consulted d/t [due to] septic shock [when an infection causes dangerously low blood pressure and organ failure] ,d+[DATE] [secondary to] peritonitis [inflammation of the peritoneum, the thin tissue lining in the abdominal wall that covers the abdominal organs] in a trach [tracheostomy] dependent patient. During a record review of the hospital discharge summary, dated [DATE], the discharge summary indicated, . Continue on abx [antibiotic] and bedside washout (a procedure that involved washing the peritoneal cavity with a saltwater solution) performed by surgery team . family opting for non-surgical management given patient's overall clinical status at this time. Patient's family opting for comfort-focused care given grave prognosis [a prediction about the course of a disease]. He [Resident 1] passed surrounding by family.