STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Park Rehabilitation Hospital	2850 Sierra Sunrise Terrace 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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 51253 Based on interview and record review, the facility failed to ensure the licensed nurses reported changes of condition to the physician for 1 of 3 residents (Resident 1) when: 1. Resident 1 had edema (swelling) that went from mild lower leg edema to deep pitting (leaves an indent in skin for a period of time) to the hips. This resulted in a transfer to hospital for fluid overload, ascites (fluid in abdomen), anasarca (fluid throughout all of body, puffy body), bilateral pleural effusions (fluid in the lungs), and exacerbated (make worse) his congestive heart failure. 2. Resident 1 had sudden new onset of 7/10 pain (severe pain) with as needed (PRN) pain medication given for first time on 8/18/24 and 8/19/24. This resulted in increased pain and discomfort. Findings: A review of facility's policy titled, Change in Condition Policy Assessment, revised on 9/17/17, indicated residents who experience a change of condition will be assessed promptly and follow up action will be taken as indicated in a timely manner. This includes any sudden and/or marked adverse change in signs, symptoms, or behavior exhibited by a patient. The licensed nurse is responsible for notifying the attending physician regarding all changes in a resident's condition. A review of Resident 1's record indicated he was admitted into this facility on 7/4/24 to rehabilitate from a hip replacement. Resident 1 had Parkinson's Disease (disorder of the nervous system), high blood pressure, and heart failure. Resident 1 was his own health care decision maker. During a record review of acute care hospital discharge notes for 7/4/2024, Resident 1 had +1 (mild) pitting (when one presses on the site, there is a pit or indentation) edema to right lower extremity and +2 (moderate) pitting to the left lower extremity. During record review of the physician admission orders on 7/4/24, Resident 1 had orders from Physician 1 for monitoring edema (swelling from fluid overload) every shift. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the Resident 1's medication orders, indicated on 8/2/24, a new order for Lasix (a medication used to release excess fluid from the body by urination along with a release of potassium) 20 milligrams (mg) every day for edema. On 8/17/24, a new order was placed for Lasix 40 mg every day, a dose increase for the worsening edema. During a record review of the Medication Administration Record (MAR) for August 2024 indicated Resident 1 had +2 pitting edema in both lower extremities from 8/3/24 through 8/15/24. On 8/16/24, Resident 1 advanced to +3 pitting (when one presses on the site, there is a deep pit that lasts for 30 seconds before going away) edema. There was no change in condition reported by nursing staff to the physician found in the record. During a review of the MAR for August 2024, on 8/18/24 and 8/19/24, Resident 1 had sudden 7/10 severe pain and was administered a strong narcotic pain medication. This was the first time in August of 2024 that Resident 1 reported pain. There was no physician notification about the new onset of severe pain by licensed nurses found in the record. During a review of a Nursing Note dated 8/19/2024 at 11:30 am, Licensed Vocational Nurse (LVN 1) documented that Resident 1's wife insisted on sending Resident 1 out to the hospital to be evaluated. LVN 1 documented Physician 2 spoke with the family and agreed that if the family and Resident 1 wanted to have an emergency room (ER) visit, then it is okay. LVN 1 documented that around 12 pm Resident 1 was sent with nonemergent transport for evaluation at the emergency room (ER) due to the family insisting that he had a decline in health. During an interview on 8/30/24 at 2:04 pm, Family Member (FM 1) stated that she had to insisted for two days for Resident 1 to go to the hospital. FM 1 stated nursing staff told her, If we send him out, they are just going to send him right back here because there is nothing, they can do for him. FM 1 stated the nurse did not attempt to send Resident 1 out, even after family's insistence. FM 1 stated Resident 1 was in severe pain, and it appeared like he was going to be dead within one day if not sent out to hospital. During a concurrent interview and record review on 10/9/24 at 1:30 pm, Director of Nursing (DON) confirmed that the edema went from slight +1, to moderate +2, then to severe pitting edema +3. DON confirmed there was no change of condition reported by nursing staff to the physician. DON confirmed that Resident 1's new sudden onset severe pain on 8/18/24 and 8/19/24 along with the increased edema, these changes should have been reported to the physician. DON also confirmed it was by the insistence of the family that the Resident 1 was sent out to hospital for evaluation not the licensed nursing staff. DON stated the licensed nurses should have reported these changes to the physician and that their policy was not followed. During a record review of acute care hospitals ER admission assessment on 8/19/2024, indicated Resident 1 had multiple severe health issues such as infection, low potassium (regulates a regular heart rate), diminished breath sounds, edema both lower extremities extending all the way up to Resident 1's hips, anasarca, bilateral pleural effusions, fluid overload, and was ill and weak appearing. Resident 1 received emergent care and treatment and returned to the long-term care facility on 8/27/24, eight days later.

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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 - Minimal harm or potential for actual harm 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. 51253 Based on interview and record review the facility failed to ensure licensed nursing staff had the skills and competencies to ensure the medical needs for one of three sampled residents (Resident 1) were met when significant changes of condition were not identified and reported to the physician. This resulted Resident 1 to be transferred to the hospital for fluid overload, ascites (fluid in abdomen), anasarca (fluid throughout all of body, puffy body), bilateral pleural effusions (fluid in the lungs), and exacerbated (make worse) congestive heart failure. Findings: A review of Resident 1's record indicated he was admitted into this facility on 7/4/24 to rehabilitate from a hip replacement. Resident had Parkinson's Disease (movement disorder of the nervous system), high blood pressure, and heart failure Resident 1 was his own health care decision maker. During a record review of acute care hospital discharge notes for 7/4/2024, Resident 1 had +1 (mild) pitting (when one presses on the site, there is a pit or indentation) edema to right lower extremity and +2 (moderate) pitting to the left lower extremity. During record review of the facility admission orders on 7/4/24, Resident 1 had orders from Physician 1 for monitoring edema every shift. During a record review of the Medication Administration Record (MAR) for August 2024, indicated Resident 1 had +2 pitting edema in both lower extremities from 8/3/24 through 8/15/24. On 8/16/24, Resident 1 advanced to +3 pitting (when one presses on the site, there is a deep pit that lasts for 30 seconds before going away) edema. There was no change in condition reported by nursing staff to the physician found in the record. During a record review of the Resident 1's medication orders, indicated on 8/2/24, a new order for Lasix (a medication used to release excess fluid from the body by urination along with a release of potassium) 20 milligrams (mg) every day for edema. During record review of Resident 1's medication orders dated 8/17/24, indicated a new order was placed for Lasix 40 mg every day, a dose increase. During a record review of Resident 1's record, there were no physician laboratory (lab) orders found to draw a baseline blood potassium (regulates a regular heart rate), level before or any monitoring after starting Lasix from 7/4/24 through 8/19/24. There were also no physicians order for any supplemental oral potassium. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an online resource National Institutes of Health (nih.gov) DailyMed, indicated Lasix is a potent diuretic (increases amount of urine produced) which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte (essential for basic life functioning) loss. Therefore, careful medical supervision is required and dose and dose schedule must be adjusted to the individual patient's needs laboratory tests serum electrolytes (particularly potassium), should be determined frequently during the first few months of Lasix therapy and periodically thereafter. A review of Resident 1's record, indicated a physician order dated 8/19/24, indicated labs to drawn for electrolyte (potassium) blood levels. The lab results dated 8/19/24, indicated a low potassium level of 3.1 millimoles per liter (mmol/L, normal blood potassium level for adults is between 3.5 and 5.5 mmol/L). During a review of the MAR for August 2024, on 8/18/24 and 8/19/24, Resident 1 had sudden 7/10 (severe) pain and was administered a strong narcotic pain medication. This was the first time in August of 2024 that Resident 1 reported pain. There was no physician notification about the new onset of severe pain by licensed nurses found in the record. During a review of a Nursing Note dated 8/19/2024 at 11:30 am, Licensed Vocational Nurse (LVN 1) documented that Resident 1's wife insisted on sending Resident 1 out to the hospital to be evaluated. LVN 1 documented Physician 2 spoke with the family and agreed that if the family and Resident 1 wanted to have an emergency room (ER) visit, then it is okay. LVN 1 documented that around 12 pm Resident 1 was sent with nonemergent transport for evaluation at the emergency room (ER) due to the family insisting that he had a decline in health. During record review of acute care hospital records dated 8/19/24, indicated Resident 1 had a low blood potassium level of 3.2 mmol/L (low). He was treated with potassium chloride. The ER admission assessment on 8/19/2024, indicated Resident 1 had multiple severe health issues such as infection, low potassium, diminished breath sounds, edema both lower extremities extending all the way up to Resident 1's hips, anasarca, bilateral pleural effusions, fluid overload, and was ill and weak appearing. Resident 1 received emergent care and treatment and returned to the long-term care facility on 8/27/24, eight days later. During an interview on 8/30/24 at 2:04 pm, Family Member (FM 1) stated that she had to insisted for two days for Resident 1 to go to the hospital. FM 1 stated nursing staff told her, If we send him out, they are just going to send him right back here because there is nothing, they can do for him. FM 1 stated the nurse did not attempt to send Resident 1 out, even after family's insistence. FM 1 stated Resident 1 was in severe pain, and it appeared like he was going to be dead within one day if not sent out to hospital. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/9/24 at 1:30 pm, Director of Nursing (DON) confirmed that the edema went from minor +1 to moderate +2 to severe pitting edema +3, and no change of condition was reported by nursing staff to the physician. DON confirmed that the patient had sudden onset severe pain on 8/18/24 and 8/19/24 which was a change in condition along with the increased edema. DON also confirmed it was by the insistence of FM 1 that the patient was sent out to an acute care facility. DON confirmed when nursing staff received the new order of Lasix, there should have been a conversation with the physician about monitoring potassium levels. DON explained nursing staff were expected to assess residents and report changes of condition to the physician timely. DON confirmed a baseline potassium level and ongoing monitoring should have happened at the facility for Resident 1 when Lasix was started, and this put Resident 1 as risk for cardiac irregularities. A review of facility's policy titled, Change in Condition Policy Assessment, revised on 9/17/17, indicated residents who experience a change of condition will be assessed promptly and follow up action will be taken as indicated in a timely manner. This includes any sudden and/or marked adverse change in signs, symptoms, or behavior exhibited by a patient. The licensed nurse is responsible for notifying the attending physician regarding all changes in a resident's condition.