

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555777	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Bishop Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 Pioneer Lane Bishop, CA 93514	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47206</p> <p>Based on observation, interview, and record review, the facility failed to follow its policy and procedure when:</p> <ol style="list-style-type: none"> One of three residents (Resident 1) did not receive medications timely as prescribed by the physician. Three of three sampled residents, Resident 1, Resident 2, and Resident 3, experienced a delay in response to their call lights. <p>These failures had the potential to put the health and safety of three clinically compromised residents (Resident 1, Resident 2, and Resident 3) at risk.</p> <p>Findings:</p> <ol style="list-style-type: none"> During a review of Resident 1's admission record (contains important information about the patient such as their personal details, the reason for their admission, and their medical history), the document indicated Resident 1 was admitted to the facility on [DATE], with a diagnosis that included unspecified peripheral vascular disease (a condition which narrowed blood vessels slows blood flow to the limb). <p>During an interview and observation with Resident 1 on June 12, 2024, at 2:07 PM, Resident 1 stated that he noticed a decrease in the quantity of pills he was taking in the morning. When he raised his concerns to Licensed Vocational Nurse (LVN 1) LVN 1 informed Resident 1 that an error had occurred at the pharmacy. LVN 1 explained that a nurse had signed for the delivered medications from the pharmacy, but it was not placed in Resident 1's medication cart drawer for availability during medication administration.</p> <p>During an interview with Licensed Vocational Nurse (LVN 1), June 12, 2024, at 5:00 PM, LVN 1 stated that she had transmitted a refill request to the pharmacy via fax on June 15, 2024, and when she contacted the pharmacy to check the status of the requested medications, she was informed that the requested medications had been delivered to the facility.</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 with Registered Nurse (RN 1), on June 12, 2024, at 5:35 PM, RN 1 acknowledged receiving the delivered medications from the pharmacy. Additionally, RN 1 stated that she informed a nurse at a different station about the delivered medications that she placed in the medication room to be stored in the medication cart.</p> <p>During an interview with Licensed Vocational Nurse 2 (LVN 2) on June 12, 2024, at 5:30 PM, LVN 2 acknowledged that RN 1 informed her about the delivered medications, but she forgot to notify LVN 1 about the delivered medications. LVN 2 concurred that LVN 1 should have checked the medication room to verify the delivery of her requested medications.</p> <p>During an interview with the Director of Nursing (DON), on June 12, 2024, at 5:38 PM, the DON acknowledged the medications that were not administered in accordance with the Medication Administration Record (MAR) and the corresponding note/reason indicated.</p> <p>During a review of Resident 1's records, the facility provided document titled Medication Administration Record (MAR) dated May 1, 2024, through May 31, 2024. The MAR indicated the following medications were not administered as prescribed:</p> <ul style="list-style-type: none"> - Apixaban 5 mg: 5 doses were missed from May 15 to May 18, 2024 - Tamsulosin 0.4 mg: 2 doses were missed from May 17 to May 18, 2024 - Diltiazem HCL 120 mg: 2 doses were missed from May 17 to May 18, 2024 - Furosemide 40 mg: 3 doses were missed from May 16 to May 18, 2024 - Digoxin 125 mcg: Not administered doses on May 15, 16, and 18, 2024. <p>During a review of the undated facility-provided document, the policy and procedure (P&P) titled Administering Medications, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed.</p> <p>2. During a review of Resident 1's admission record (contains important information about the patient such as their personal details, the reason for their admission, and their medical history), the document indicated Resident 1 was admitted to the facility on [DATE], with a diagnosis that included unspecified peripheral vascular disease (a condition which narrowed blood vessels slows blood flow to the limb).</p> <p>During an interview and observation of Resident 1 on June 12, 2024, at 2:07 PM, Resident 1 stated the staff usually takes between half an hour to one hour to respond during the night, from 8:00 PM until dawn. He expressed that he has been left unattended for as long as 16 hours. Furthermore, Resident 1 noted that while seeking assistance, staff members sometimes inform him that they will assist him after attending to another resident, but then they do not return for hours or sometimes not at all.</p> <p>(continued on next page)</p>		

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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 a review of Resident 2's admission record (contains important information about the patient such as their personal details, the reason for their admission, and their medical history), the document indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis that included hypertension (HTN - the pressure of blood is too high).</p> <p>During an interview with Resident 2 on June 12, 2024, at 2:45 PM, Resident 2 stated the staff takes close to an hour to respond to call lights during the night. Resident 2 concluded the facility simply does not have enough staff available.</p> <p>During a review of Resident 3's admission record (contains important information about the patient such as their personal details, the reason for their admission, and their medical history), the document indicated Resident 3 was admitted to the facility on [DATE], with a diagnosis that included chronic respiratory failure with hypoxia. (a condition where a patient does not have enough oxygen [gas essential to living] in the tissues or carbon dioxide [respiratory drive in a human body] in the blood which makes it hard to breath).</p> <p>During an interview with Resident 3 on June 12, 2024, at 3:20 PM, Resident 3 stated the wait times for call lights ranges from half an hour to nearly two hours, with the situation being particularly challenging from around 11:00 PM through the early morning hours. Resident 3 also emphasized that although his personal needs often revolve around requesting ice, he is worried about other residents who may have more urgent needs.</p> <p>During an interview with the DON on June 13, 2024, at 5:38 PM, the DON stated the call lights response by the staff is poor during nighttime due to having only four Certified Nursing Assistants (CNAs) for the entire facility.</p> <p>During a review of the undated facility's policy and procedure (P&) titled, Answering the Call Light, The P&P indicated, The purpose of this procedure is to respond to the residents requests and needs.</p>