STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555910	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trellis Chino	5454 Walnut Avenue Chino, CA 91710

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 45849 Based on interview, record review, document review, and facility policy review, the facility failed to transmit discharge Minimum Data Set (MDS) assessments for 2 (Resident #16 and Resident #40) of 3 sampled residents reviewed for resident assessment. Findings included: A facility policy titled MDS Completion and Submission Timeframes, dated July 2017, indicated, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy indicated, 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, dated 10/2023, indicated, Discharge assessment refers to an assessment required on resident discharge from the facility. 1. An Admission Record revealed the facility admitted Resident #16 on 12/12/2023. According to the Admission Record, the resident discharged from the facility on 01/17/2024. The discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/17/2024, revealed Resident #16 discharged home on 01/17/2024. 2. An Admission Record revealed the facility admitted Resident #40 on 01/10/2024. According to the Admission Record, the resident discharged from the facility on 01/3/2024. The discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/30/2024, revealed Resident #40 discharged home on 01/30/2024. In an interview on 06/05/2024 at 10:54 AM, the MDS Nurse stated Resident #16's discharge MDS with an ARD of 01/17/2024 and Resident #40's discharge MDS with an ARD of 01/30/2024 had not been transmitted. The MDS Nurse stated the discharge MDS should have been transmitted within 14 days of the ARD. In an interview on 06/05/2024 at 12:47 PM, the Director of Nursing stated her expectation was that MDS assessments should be submitted in a timely manner following the RAI manual guidelines. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/06/2024 at 8:22 AM, the Administrator stated his expectation was that MDS assessments were completed and transmitted in the required timeframe.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to provide conduct an assessment and monitor the provision of a nebulizer treatment for 1 (Resident #165) of 1 sampled resident reviewed for respiratory care. Findings included: A facility policy titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised in 10/2010, indicated, The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. The policy specified, Documentation The following information should be recorded in the resident's medical record. 1. The name, title and initials of the person administering the treatment. 2. The date, time and length of treatment (treatment administration record). 3. The type and amount of medication administered (medication administration record). 4. The type and source of gas. 5. Pulse, respiratory rate and lung sounds before and after treatment. 6. Pulse during treatment. 7. Amount and characteristics of sputum production. 8. The resident's tolerance of the treatment. 9. Any adverse effects of the medication and/or treatment and physician notification, if applicable. An Admission Record indicated the facility admitted Resident #165 on 05/23/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute respiratory failure with hypoxia (insufficient oxygen level), chronic pulmonary edema (fluid accumulates in lung tissue), and acute on chronic congestive heart failure. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/25/2024, revealed Resident #165 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required oxygen therapy. Resident #165's care plan, initiated on 06/03/2024 indicated the resident had altered respiratory status and difficulty breathing related to pulmonary edema and acute respiratory failure with hypoxia. Interventions directed staff to administer medications/puffers as ordered and monitor for effectiveness and side effects. Resident #165's Order Summary Report, with active orders as of 06/05/2024, revealed an order dated 05/23/2024, for Xopenex nebulization solution 0.63 milligrams (mg) per 3 milliliters (ml) with instructions for the resident to inhale 3 ml via nebulizer every six hours for respiratory failure. Resident #165's medication administration record for June 2024, revealed no evidence to indicate the resident's pulse, respiratory rate, or lung sound before or after their nebulizer treatment, the resident's pulse during treatment, or the resident's tolerance to the treatment. Resident #165's treatment administration record for June 2024, revealed no evidence to indicate the resident's pulse, respiratory rate, or lung sound before or after their nebulizer treatment, the resident's pulse during treatment, or the resident's tolerance to the treatment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #165's Progress Notes, for the timeframe 05/06/2024 to 06/05/2024, revealed no evidence to indicate the resident's pulse, respiratory rate, or lung sound before or after their nebulizer treatment, the resident's pulse during treatment, or the resident's tolerance to the treatment. On 06/05/2024 at 12:39 PM, the surveyor observed as Resident #165 sat on the side of their bed. The resident stated they had not received their nebulizer treatment yet; however, the nebulizer mask and medication cup were on top of a tissue box in the resident's room. According to Resident #165, the nurse placed the medication in the cup and turned the machine on, but did not stay in their room during the entire treatment. Resident #165 stated they turned off the nebulizer machine when it was done. Resident #165 stated the nurse did not listen to their lungs before or after they received their nebulizer treatment. During an interview on 06/05/2024 at 12:26 PM, Licensed Vocational Nurse (LVN) #1 stated after a resident finished their nebulizer treatment, the nurse should have the resident rinse their mouth and check the resident's oxygen saturation and respirations, but she did not think it would be documented anywhere. During an interview on 06/05/2024 at 3:33 PM, LVN #3 stated Resident #165 put on and took off their nebulizer mask and turned the machine off when they were done. LVN #3 stated she did not check the resident's lung sounds or vital signs when she administered the resident their nebulizer treatment and could not recall anywhere that she was supposed to document it. During an interview on 06/06/2024 at 8:45 AM, the Director of Nursing stated the nurse should document if a resident did not receive their full nebulizer treatment and the nurse should assess the resident's oxygen saturation, respiration, and lung sounds before, during, and after a treatment. During an interview on 06/06/2024 at 9:04 AM, the Administrator stated the resident should be assessed during a nebulizer treatment as per the facility protocol.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to monitor the dialysis fistula for 1 (Resident #165) of 1 sampled resident reviewed for dialysis. Findings included: A facility policy titled, Hemodialysis Catheters - Access and Care of, revised in 02/2023, specified under the section titled, Care of AVFs [arteriovenous fistula] and AVGs [arteriovenous graft], 3. Care involves the primary goals of preventing infection and maintaining patency of the catheter (preventing clots). 4. To prevent infection and/or clotting: a. Keep access site clean at all times. b. Do not use the access site arm to take blood samples, administer IV [intravenous] fluids or give injections. c. Needle access for hemodialysis should be rotated. d. Check for signs of infection (warmth, redness, tenderness, or edema) at the access site when performing routine care and at regular intervals. e. Do not use the access arm to take blood pressure. f. Advise the resident not to sleep on, wear tight jewelry or lift heavy objects with the access arm. g. Check the color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals. h. Check patency of the site at regular intervals. Palpate the site to feel the 'thrill,' or use a stethoscope to hear the 'whoosh' or 'bruit' of blood flow through the access. An Admission Record indicated the facility admitted Resident #165 on 05/23/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of end stage renal disease with dependence on renal dialysis. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/25/2024, revealed Resident #165 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident received dialysis. Resident #165's care plan, initiated 06/01/2024, indicated the resident required hemodialysis due to end stage renal disease and was at risk for bleeding at the access site, weight fluctuation, fluid overload, and hypotension. Interventions directed staff to observe the access/shunt/catheter site for signs or symptoms of complication (i.e., redness, pain, bleeding, unusual bruising, pus/drainage, absent thrill/bruit over graft site, complaints of coldness/numbness of hand/arm or chest pain) and report abnormal finding to physician. Resident #165's Order Summary Report, with active orders as of 06/05/2024, revealed an order dated 05/23/2024 that directed staff to check the resident's left arm fistula site dressing every shift, leave intact for four to six hours following dialysis., change if soiled or fallen off. If bleeding was noted from dialysis access site, immediately apply pressure to site to stop bleeding. If bleeding did not subside, call the physician, and initiate emergency medical services immediately. There was also another order dated 05/23/2024, that directed staff to monitor the resident's left arm AV fistula site for bleeding, redness, discharge, swelling, pain and notify the physician every shift. There was not an order to check the thrill and bruit of the resident's dialysis access site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Dialysis Communication Report, for Resident #165. dated 05/24/2024, revealed no documentation of the status of the resident's access site to indicate if there was redness, edema, or drainage, and there was no documentation that the resident's shunt was checked for thrill and bruit prior to dialysis. T The Dialysis Communication Report, for Resident #165 dated 05/27/2024, revealed no documentation of the status of the resident's access site to indicate if there was redness, edema, or drainage, and there was no documentation that the resident's shunt was checked for thrill and bruit prior to dialysis. The Dialysis Communication Report, for Resident #165 dated 05/29/2024, revealed no documentation of the status of the resident's access site to indicate if there was redness, edema, or drainage, and there was no documentation that the resident's shunt was checked for thrill and bruit prior to dialysis. The Dialysis Communication Report, for Resident #165 dated 05/31/2024, revealed no documentation of the status of the resident's access site to indicate if there was redness, edema, or drainage, and there was no documentation that the resident's shunt was checked for thrill and bruit prior to dialysis. The Dialysis Communication Report, for Resident #165 dated 06/04/2024, revealed no documentation of the status of the resident's access site to indicate if there was redness, edema, or drainage, and there was no documentation that the resident's shunt was checked for thrill and bruit prior to dialysis. Resident #165's medication administration record and treatment administration record for June 2024, revealed no documentation the thrill and bruit of the resident's access site was assessed. During an interview on 06/05/2024 at 10:04 AM, Resident #165 stated the staff had never felt or listened to their fistula and stated maybe they did not know and needed to be educated. During an interview on 06/05/2024 at 12:26 PM, Licensed Vocational Nurse (LVN) #1 stated that when a resident returned from dialysis, she checked their skin to make sure there were no new areas of concern and checked the access site. LVN #1 stated she would also check the thrill and bruit of the fistula if the resident had one and it should be documented on the dialysis communication form. LVN #1 stated Resident #165 returned from dialysis after her shift ended so she had not checked the resident's access site before. LVN #1 stated she did not check the thrill or bruit prior to the resident going to dialysis. During a follow-up interview on 06/05/2024 at 2:26 PM, LVN #1 reviewed Resident #165's Dialysis Communication Report dated 06/04/2024, and confirmed that she signed the report. LVN #1 stated she did check the thrill and bruit but forgot to mark it on the form. LVN #1 stated she did not know why the resident would say it was not done because she did it. LVN #1 stated she forgot that she had done it the previous day when she was asked about it in a previous interview. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/2024 at 3:33 PM, LVN #3 stated that when a resident came back from dialysis, she would check the resident's skin, check the access site, check for thrill and bruit, and document it on the communication form. After review of the Resident #165's Dialysis Communication Report dated 05/29/2024, LVN #3 confirmed that it was her signature and that the thrill and bruit were not documented. LVN #3 stated she must have forgotten. LVN #3 stated she knew they needed orders for care of the access site and monitoring, but was unsure what all the orders were needed for a dialysis resident. During a telephone interview on 06/06/2024 at 8:24 AM, LVN #4 stated that when a resident returned from dialysis, she checked their access site and checked for thrill and bruit. LVN #4 stated this all should be documented on the communications form. LVN #4 acknowledged she must have forgotten to document her assessment. During an interview on 06/06/2024 at 8:45 AM, the Director of Nursing (DON) stated that when a resident returned from dialysis, the nurse should collect the binder (that held the communication forms), check the resident's vital signs, check the dressing to the access site and monitor the resident for bleeding but leave the dressing on the resident for four to six hours and then remove it, and assess for the thrill and bruit. The DON stated the nurses should document their assessment on the communication form, sign the post dialysis sheet, and return it to the binder. During an interview on 06/06/2024 at 9:04 AM, the Administrator stated he expected the nurses to follow the dialysis protocol and complete the necessary documentation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45555 Based on interview, record review, and facility policy review, the facility failed to ensure ordered medication was available in the facility for 1 (Resident #32) of 6sampled residents reviewed for unnecessary medications. Findings included: A facility policy titled, Medication Orders and Receipt Record, revised in 04/2007, revealed no evidence related to receiving medications in a timely manner from the pharmacy. An Admission Record indicated the facility admitted Resident #32 on 05/15/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of paraplegia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of05/18/2024, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had moisture associated skin damage (MASD). Resident #32's care plan, initiated on 05/16/2024 indicated the resident had impaired skin integrity present upon admission as evidenced by skin discoloration. Interventions directed staff to administer treatments as ordered and monitor for effectiveness. Resident #32's Order Summary Report, with active orders as of 06/05/2024, revealed an order dated 05/28/2024, for nystatin-triamcinolone cream with instructions for the cream to be applied to the resident's coccyx extending to the left and right buttocks every day shift for fungal MASD for 21 days until finished. Resident #32's treatment administration record (TAR) for June 2024, revealed for the dated 06/01/2024 to 06/05/2024, the staff documented a 9, which indicated Other /See Nurses Notes, for the administration of the nystatin-triamcinolone cream. Resident #32's Progress Notes, dated 05/29/2024 at 9:41 AM, 06/01/2024 at 11:26 AM, 06/02/2024 at 1:03 PM, 06/03/2024 at 10:40 AM, 06/04/2024 at 3:43 PM, and 06/05/2024 at 9:50 AM, revealed staff documented the resident's nystatin-triamcinolone cream was pending delivery from pharmacy. During an interview on 06/05/2024 at 11:28 AM, Licensed Vocational Nurse (LVN) #6 stated if he did not have a medication available to do a treatment, he would call the pharmacy to find out the delay and notify the physician. LVN #6 stated the resident should not go longer than a day without the treatment. LVN #6 stated the physician should be notified and it would be documented on the TAR or a progress note. During a follow-up interview on 06/05/2024 at 12:00 PM, LVN #6 stated he faxed the order for the nystatin-triamcinolone cream for Resident #32 the previous week to the pharmacy, but did not work over the weekend and did not follow up on it on Monday, 06/03/2024 or Tuesday, 06/04/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/2024 at 12:26 PM, LVN #1 stated if a medication was not available, she would contact the physician to ask for an alternative that could be used until that medication became available. LVN #1 stated the facility should receive the medication within 24 hours. She stated if a medication was not available for a treatment to be provided, the pharmacy and physician should be notified, and it should be documented on the medication administration record, TAR, or a progress note. During an interview on 06/06/2024 at 8:24 AM, LVN #4 stated she would follow up with the pharmacy for medications that were not available and notify the physician. During an interview on 06/06/2024 at 8:45 AM, the Director of Nursing (DON) stated if a medication was not available for a treatment, the nurse should notify the physician to get it changed if needed. The DON stated LVN #6 should have followed up with the pharmacy about Resident #32's nystatin-triamcinolone cream and then notified the physician for an alternative. During an interview on 06/06/2024 at 9:04 AM, the Administrator stated if a medication was not available the nurse should follow up with the physician to see if that particular medication was needed or if an alternative could be used, but he expected the staff to get the medication. The Administrator stated the resident should not have to wait, and it should be followed up on right away.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to store nebulizer equipment for 1 (Resident #165) of 1 sampled resident reviewed for respiratory care. Findings included: A facility policy titled, Prevention of Infection Respiratory Equipment, revised in 11/2011, specified, Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: 1. Obtain equipment 2. Wash Hands. 3. Take care not to contaminate internal nebulizer tubes. 4. Store the circuit in plastic bag, marked with date and resident's name and replace tubing and plastic bag once a week. An Admission Record indicated the facility admitted Resident #165 on 05/23/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute respiratory failure with hypoxia (insufficient oxygen level), chronic pulmonary edema (fluid accumulates in lung tissue), and acute on chronic congestive heart failure. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/25/2024, revealed Resident #165 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required oxygen therapy. Resident #165's care plan, initiated on 06/03/2024 indicated the resident had altered respiratory status and difficulty breathing related to pulmonary edema and acute respiratory failure with hypoxia. Interventions directed staff to administer medications/puffers as ordered and monitor for effectiveness and side effects. Resident #165's Order Summary Report, with active orders as of 06/05/2024, revealed an order dated 05/23/2024, for Xopenex nebulization solution 0.63 milligrams (mg) per 3 milliliters (ml) with instructions for the resident to inhale 3 ml via nebulizer every six hours for respiratory failure. On 06/03/2024 at 10:21 AM, the surveyor observed a nebulizer machine on Resident #165's nightstand with the mask and medication cup lying on top of the nightstand with fluid in the medication cup; the mask was not stored in a plastic bag. Resident #165 stated they used the machine a couple of times a day and had already used it that morning. On 06/04/2024 at 2:10 PM, the surveyor observed Resident #165's nebulizer mask and medication cup were connected to the machine with tubing, and they were lying on top of the nightstand, not stored in a plastic bag. On 06/05/2024 at 10:04 AM, the surveyor observed Resident #165's nebulizer mask and medication cup were connected to the nebulizer machine by tubing and was lying on top of a tissue box on the nightstand, not stored in a plastic bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/2024 at 12:39 PM, the surveyor observed as Resident #165 sat on the side of their bed. The resident stated they had not received their nebulizer treatment yet; however, the nebulizer mask and medication cup were on top of a tissue box, not stored in a plastic bag. During an interview on 06/05/2024 at 12:26 PM, Licensed Vocational Nurse (LVN) #1 stated respiratory equipment should be stored in a plastic bag when not in use. During an interview on 06/05/2024 at 1:04 PM, Certified Nursing Assistant (CNA) #2 stated respiratory equipment should be stored in a plastic bag when not being used. CNA #2 entered Resident #165's room and confirmed the resident's nebulizer mask was not stored in a plastic bag and there was not a bag available in the resident's room to store it in. On 06/05/2024 at 2:26 PM, LVN #1 confirmed Resident #165's nebulizer equipment was not stored in a plastic. During an interview on 06/05/2024 at 3:33 PM, LVN #3 stated nebulizer equipment should be stored in a plastic bag when not in use. During an interview on 06/06/2024 at 8:24 PM, LVN #4 stated nebulizer equipment should be stored in a bag when dry. During an interview on 06/06/20224 at 8:45 AM, the Director of Nursing stated respiratory equipment should be stored in a plastic bag when not in use. During an interview on 06/06/2024 at 9:04 AM, the Administrator stated respiratory equipment should be cleansed and stored appropriately according to the facility protocol.