STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056258	A. Building B. Wing	10/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Redding Care Center	2490 Court Street Redding, CA 96001

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that one of 16 sampled residents (Resident 7), record contained documentation that their physician had been notified of a change in their condition. This failure had the potential to put this high-risk residents at increased risk of becoming increasingly ill without it being recognized, and treated in an appropriate, and timely manner by her physican. Findings: A review of a facility policy, titled, Change of Condition Notification, revised 4/15, indicated that physician would be informed of changes in condition in a timely manner. This would include significant changes in a resident's physical, mental or psychosocial status, or having to do with a significant change in treatment. Resident 7's medical record was reviewed, and indicated that they had been admitted [DATE], with [DIAGNOSES REDACTED]. A review of a paper COVID-19 assessment required each shift indicated that for Resident 7, on the night shift of 9/20/20, the nurse noted a change in lung sounds (rales: rattling sound in lungs related to secretions), but there was no indication on the paper form, or in the electronic medical record that the doctor was notified. Further review indicated that there was no paper COVID assessment done for Resident 7 on day shift on 9/21/20. A review of a paper COVID-19 assessment for Resident 7, done on the night shift of 9/21/20, indicated that the nurse noted the lung sounds still had rales, but there is no indication on the paper form, or in computer that the doctor was notified. A review of a paper COVID assessment for Resident 7, done on day shift 9/22/20, indicated that Resident 7 complained of losing her sense of smell and taste, and had an episode of vomiting, but there was no indication on the paper form, or in computer that the doctor was notified. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a paper COVID assessment for Resident 7, done on night shift 9/22/20, indicated that Resident 7 had shallow respirations, diminished lung sounds, and a non-productive cough, but there was no indication on the paper form, or in computer that the doctor was notified. During an interview, on 10/11/20 at 12:30 PM, Registered Nurse (RN 1) confirmed that the RNs on the Red Zone did not have access to the electronic medical record. RN 1 stated they should have been given emergency authorization to have access. She confirmed that the RNs should have been doing resident assessments on paper instead, which should include documentation that the physician is notified of changes in a resident condition.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that 16 of 16 sampled residents received accurate comprehensive physical assessments, when Registered Nurses (RNs) were often not assigned to their care, and when many shifts had no documented record of physical assessments having been conducted by a RN. This failure had the potential to put high-risk, COVID-19-positive residents at increased risk of becoming increasingly ill without it being recognized, and treated in an appropriate, and timely manner. Findings: A review of a facility policy, titled, Change of Condition Notification, revised ,[DATE], indicated that physician would be informed of changes in condition in a timely manner. This would include significant changes in a resident's physical, mental or psychosocial status, or having to do with a significant change in treatment. Licensed nursing would be responsible to assess for deterioration in health and determine what nursing interventions would be appropriate. Nurses would document their assessments along with the date, and time and pertinent details. Following a change in condition, nursing would document each shift for at least seventy-two hours. A review of a facility policy, titled, Progress Notes, revised ,[DATE], indicated that all disciplines at the facility would document progress notes in the appropriate section of the resident's medical record according to professional standards and regulations. Progress notes would reflect the resident's current status, progress or lack of progress, changes in condition, and other relevant information. All progress notes must be signed with the writer's name, title, and are to be documented in a timely manner. A review of Progress Notes, and COVID-19 nursing assessment forms (Admission Note-COVID-19, and COVID-19 Q (every) Shift Monitoring forms), for Residents 1 through 16, from the time they tested positive for COVID-19, until they died , or were transferred to a hospital, indicated that the facility had a combined 47-days where nursing did not document progress notes per facility policy, and a combined 84-shifts where nursing did not complete COVID-19 specific assessments. Resident 1's record was reviewed, and indicated that they were admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's clinical record, Progress Notes, dated [DATE], indicated that Resident 1 tested positive for COVID-19, and was transferred to the COVID-19 positive quarantine area (isolation area to limit the spread of the disease) of the facility. A review of Resident 1's Progress Notes, dated [DATE], indicated that Resident 1 was removed from COVID-19 quarantine on [DATE]. A review of Resident 1's Progress Notes, indicated that nursing staff did not complete assessments of Resident 1's health status on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], and [DATE]. Further review indicated that Resident 1 died on [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 2's record was reviewed, indicated that they had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 2's clinical record, Progress Notes, dated [DATE], indicated that Resident 2 had tested positive for COVID-19 on [DATE]. Further review of Resident 2's Progress Notes indicated that nursing staff did not complete assessments of Resident 2's health status on ,[DATE], and [DATE]. Further review indicated that Resident 2 died on [DATE]. Resident 3's record was reviewed, and indicated that they had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 3's clinical record, Progress Notes, dated [DATE], indicated that Resident 3 had tested positive for COVID-19 on [DATE]. Further review of Resident 3's Progress Notes indicated that nursing staff did not complete assessments of Resident 3's health status on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], and [DATE]. Further review indicated that Resident 3 died on [DATE]. Resident 4's record was reviewed, and indicated that they had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 4's clinical record, Progress Notes, dated [DATE] indicated that Resident 4 had tested positive for COVID-19, and was transferred to the COVID-19 positive quarantine area of the facility. A review of Resident 4's Progress Notes, dated [DATE], indicated that Resident 4 was removed from COVID-19 quarantine on [DATE]. A review of Resident 4's Progress Notes indicated that nursing staff did not complete assessments of Resident 4's health status on ,[DATE], ,[DATE], and [DATE]. Further review indicated that Resident 4 died on [DATE]. Resident 5's record was reviewed, and indicated that they had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 5's clinical record, Progress Notes, dated [DATE], indicated that Resident 1 had tested positive for COVID-19, and was transferred to the COVID-19 positive quarantine area of the facility. A review of Resident 4's Progress Notes, dated [DATE] indicated that Resident 4 was removed from COVID-19 quarantine on [DATE]. A review of Resident 5's Progress Notes indicated that nursing staff did not complete assessments of Resident 5's health status on ,[DATE]/, ,[DATE], ,[DATE], ,[DATE], ,[DATE], and [DATE]. Further review indicated that Resident 5 died on [DATE]. Resident 6's record was reviewed, and indicated that they had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 6's clinical record, Progress Notes, dated [DATE], indicated that Resident 6 had tested positive for COVID-19, and was transferred to the COVID-19 positive quarantine area of the facility. A review of Resident 6's Progress Notes, dated [DATE] indicated that Resident 4 was removed from COVID-19 quarantine on [DATE]. A review of Resident 6's Progress Notes indicated that nursing staff did not complete assessments of Resident 6's health status on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], and [DATE]. Further review indicated that Resident 6 died on [DATE]. Resident 7's medical record was reviewed, and indicated that they had been admitted [DATE], with [DIAGNOSES REDACTED]. Resident 7 was transferred to the hospital on [DATE] where she subsequently died . A review of a facility line list (record of residents, and dates they were tested for COVID-19) indicated that Resident 7 tested positive for COVID-19 on [DATE], and the facility knew about it on [DATE]. Review of a Progress Note from [DATE], indicated Resident 7 was moved to the Red Zone (for COVID-19 isolation). A review of a physician orders [REDACTED]. A review of Resident 7's Progress Notes indicated that from [DATE] to [DATE], and from [DATE] to [DATE], nurses did not document an assessment for Resident 7. A review of a paper COVID-19 assessments required each shift indicated that for Resident 7, on night shift [DATE], the nurse did not complete the resident identifying information on each form, did not sign or date the form, did not document in the required spot that Resident 7 was on the high-risk medication [MEDICATION NAME] ([MEDICATION NAME]), and did not document in the required spot that Resident 7 had been started on [MEDICAL CONDITION] therapy ([MEDICATION NAME]). Further review indicated the nurse noted a change in lung sounds (rales: rattling sound in lungs related to secretions), but there was no indication on the paper form, or in computer that the doctor was notified. Further review indicated that there was no paper COVID assessment done for Resident 7 on day shift on [DATE]. A review of a paper COVID-19 assessment for Resident 7, done on the night shift of [DATE], indicated the nurse did not complete the resident identifying information on each form, did not sign or date the form, and did not indicate that Resident 7 was on the high-risk medication, or [MEDICAL CONDITION] therapy. Further review indicated the nurse noted the lung sounds still had rales, but there is no indication on the paper form, or in computer notes that the doctor was notified that the lungs were no longer clear. A review of a paper COVID assessment for Resident 7, done on day shift [DATE], indicated the nurse did not document any of Resident 7's vital signs, or that she was on a high-risk blood-thinning medication, or [MEDICAL CONDITION] therapy. The nurse indicated that Resident 7 complained of losing her sense of smell and taste, and had an episode of vomiting, but there was no indication on the paper form or in computer that the doctor was notified of these changes in Resident 7's condition. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a paper COVID assessment for Resident 7, done on night shift [DATE], indicated the nurse did not document four out of five vital signs, did not complete the resident's identifying information, did not sign or date the form, did not indicate Resident 7 was on a high-risk blood-thinning medication, or [MEDICAL CONDITION] therapy. The form indicated Resident 7 had shallow respirations, diminished lung sounds, and a non-productive cough, but there was no indication on the paper form or in computer that the doctor was notified of these changes in Resident 7's condition. Further review, indicated that there was no paper COVID assessment done for Resident 7 on night shift [DATE]. A review of a paper COVID assessment for Resident 7, done on day shift [DATE], indicated the nurse did not sign and date the form, did not complete the necessary resident identifying information, and did not document in the required sections that Resident 7 was now on two high-risk blood thinning medications ([MEDICATION NAME], and [MEDICATION NAME]) and on [MEDICAL CONDITION] therapy. Further review, indicated that there was no paper COVID assessment done for Resident 7 on night shift [DATE]. A review of a paper COVID assessment for Resident 7, done on day shift [DATE], indicated the nurse did not document resident 7's vital signs. The form was missing two pages, and had no signature. A review of a paper COVID assessment for Resident 7, done on night shift [DATE], indicated the nurse did not document resident 7's identifying information on two of three pages, did not sign and date the form, and did not document that Resident 7 was on [MEDICAL CONDITION] therapy, or on [MEDICATION NAME]. A review of a paper COVID assessment for Resident 7, timed from 6 PM to 6 AM, is lacking the date on the form, Resident 7's vital signs, her identifying information on two of three pages, lacks documentation about [MEDICAL CONDITION] therapy, and is not signed. Further review, indicated that there was no paper COVID assessment done for Resident 7 on day and night shifts [DATE], on day and night shifts [DATE], or on day shift [DATE]. A review of a paper COVID assessment for Resident 7, done on night shift [DATE], indicated the nurse did not document resident 7's vital signs. The form was missing two pages and has no signature. A review of a paper COVID assessment for Resident 7, dated for night shift [DATE], was signed and dated as [DATE]. It lacked Resident 7's vital signs, identifying information on two pages, skipped several sections of assessment, and contained no meaningful documentation about Resident 7 being on [MEDICAL CONDITION] therapy, or two blood-thinners. A review of Resident 7's medical record indicated she was transferred to the hospital on [DATE], after she coughed up blood and had difficulty breathing. She was readmitted to the facility on night shift [DATE]. Further review, indicated that there was no paper COVID assessment done for Resident 7 on day or night shifts on [DATE], or on the day shift of [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a paper COVID assessment for Resident 7, dated for night shift [DATE], did not include the entire second page of assessments, and did not include a blood pressure recording. Further review, indicated that there was no paper COVID assessment done for Resident 7 on day or night shifts on [DATE]. A review, of Resident 7's medical record indicated she was transferred to the hospital on [DATE]. Resident 8's medical record was reviewed, and indicated that they had been admitted [DATE], with [DIAGNOSES REDACTED]. Resident 8 was transferred to the hospital on [DATE], where he subsequently died . A review of a facility line list indicated that Resident 8 tested positive for COVID-19 on [DATE]. A review of COVID-19 Q Shift Monitoring assessment forms for Resident 8, from ,[DATE] to [DATE], indicated that forms were not completed for the ,[DATE] afternoon and night shift, for any shifts on ,[DATE], and ,[DATE], or for the [DATE] night shift. Resident 9's medical record was reviewed, and indicated that they had been admitted [DATE], with [DIAGNOSES REDACTED]. Resident 9 was transferred to the hospital on [DATE], where he subsequently died . A review of a facility line list indicated that Resident 9 tested positive for COVID-19 on [DATE]. A review of Progress Notes for [DATE], indicated the facility was notified that Resident 9 was positive for COVID-19. A review of a Census List record showing room changes indicated Resident 9 was moved to the Red Zone on [DATE]. A review of COVID-19 Q Shift Monitoring assessment forms for Resident 9, from ,[DATE] to [DATE], indicated that forms were not completed for ,[DATE] night shift, for any shifts on ,[DATE], and ,[DATE], for , [DATE], night shift, for any shifts ,[DATE] through [DATE]. Resident 10's record was reviewed, and indicated that they had been admitted on [DATE], with [DIAGNOSES REDACTED]. Resident 10 was transferred to the hospital on [DATE], where she subsequently died . A review of a facility line list indicated that Resident 10 tested positive for COVID-19 on [DATE], and again on [DATE]. A review of Progress Notes for [DATE], indicated the facility was notified that Resident 10 was still positive for COVID-19. A review of a Census List record showing room changes indicated Resident 10 was moved to the Red Zone on [DATE]. A review of COVID-19 Q Shift Monitoring assessment forms for Resident 10, from ,[DATE] to [DATE], indicated that no assessment forms were completed on the ,[DATE] morning and night shifts, ,[DATE] night shift, or any shifts on ,[DATE] through [DATE]. A review of medical records for Resident 10 indicated there was no Progress Notes documented by nursing on [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 11's medical record was reviewed, and indicated that they had been readmitted on [DATE], from the hospital with [DIAGNOSES REDACTED]. Resident 11 was transferred to the hospital on [DATE], where he subsequently died . A review of a facility line list indicated that Resident 11 tested positive for COVID-19 on [DATE]. A review of Progress Notes, for [DATE], indicated that Resident 11 had a fever and was sent to the Emergency Department (ED) to be tested . He returned to the facility with a [DIAGNOSES REDACTED]. Further review of Progress Notes for Resident 11 indicated nursing did not complete a progress note on [DATE]. A review of COVID-19 Q Shift Monitoring assessment forms for Resident 11, from ,[DATE] to [DATE], indicated that no assessment forms were completed during the time frame of being COVID-positive. Further review of the records the facility provided indicated that no such assessment forms were completed for Resident 11 after the morning shift on [DATE], through to hospitalization . Resident 12's medical record was reviewed, and indicated that they had been admitted on [DATE], with [DIAGNOSES REDACTED]. Resident 12 was transferred to the hospital on [DATE], where she subsequently died . A review of a facility line list indicated that Resident 12 tested positive for COVID-19 on [DATE]. A review of Progress Notes, dated [DATE], indicated the facility was notified that Resident 12 was COVID-positive on [DATE], and moved to the Red Zone. Further review of Progress Notes for Resident 12 indicated nursing did not complete a progress note on [DATE]. A review of COVID-19 Q Shift Monitoring assessment forms for Resident 12, indicated that none were completed after night shift on [DATE], through to hospitalization . Resident 13's record was reviewed, and indicated that they had been admitted on [DATE], with [DIAGNOSES REDACTED]. A review of a facility line list indicated Resident 13 tested positive for COVID-19 on [DATE]. A review of Progress Notes, dated [DATE], indicated the facility was notified that Resident 13 was COVID-positive on [DATE]. A review of Progress Notes, dated [DATE], indicated that Resident 13 was on the Red Zone. Further review of Progress Notes, dated [DATE], indicated Resident 13 no longer in need of COVID isolation and was moved out of the Red Zone. Further review of Progress Notes indicated that nursing did not document any Progress notes for Resident 13 on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], and [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 14's medical record was reviewed, and indicated that they had been admitted on [DATE], with [DIAGNOSES REDACTED]. A review of a facility line list indicated that Resident 14 tested positive for COVID-19 on [DATE]. A review of Progress Notes, dated [DATE], indicated that the facility transferred Resident 14 to the hospital with symptoms of COVID-19. Further review of Progress Notes for Resident 14 for the month of ,[DATE], indicated that no nursing Progress Notes were written from [DATE] through [DATE]. There were no Progress Notes during that time frame to indicate if Resident 14 had been transferred elsewhere. No COVID-19 Q Shift Monitoring nursing assessments, requested for review from ,[DATE] through ,[DATE], were provided by the facility for review. During an interview on [DATE] at 1:45 PM, with Medical Records staff, she confirmed that the assessments were not completed by nursing. A review of a physician Discharge Summary from the hospital, dated [DATE], indicated that Resident 14 was made comfort care, and died at the hospital from [MEDICAL CONDITION]. Resident 15's was reviewed, and indicated that they had been admitted [DATE], with [DIAGNOSES REDACTED]. A review of a lab report, dated [DATE], indicated Resident 15 was tested for COVID-19 on [DATE], the specimen received by the lab on [DATE], and the results were positive for COVID-19. A review of Progress Notes, dated [DATE], indicated Resident 15 was transferred to the hospital due to critical decline in kidney function. The note indicated that he would go home following hospitalization . A review of COVID-19 Q Shift Monitoring nursing assessments for Resident 15, requested for review from [DATE] through [DATE], indicated that the following nursing assessments were not done on the ,[DATE], morning and night shifts, ,[DATE] all shifts, ,[DATE] all shifts, and [DATE] morning, and afternoon shifts. A review of a physician Discharge Summary, dated [DATE], indicated that Resident 15 was made comfort care and died at the hospital from [MEDICAL CONDITION], and [MEDICAL CONDITION] (infection that spread to multiple organs, causing them to fail). Resident 16's medical record was reviewed, and indicated that they had been admitted on [DATE], with [DIAGNOSES REDACTED]. A review of a facility line list indicated that Resident 16 tested positive for COVID-19 on [DATE]. A review of Progress Notes, dated [DATE], indicated Resident 16 passed away that morning at the facility. Further review of Progress Notes for Resident 16, from [DATE] to [DATE], indicated that nursing did not document Progress Notes on [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of COVID-19 Q Shift Monitoring nursing assessments of Resident 16, from ,[DATE] to [DATE], indicated that nursing did not do assessments for any shifts on those dates. During an interview, on [DATE] at 12:15 PM, Licensed Vocational Nurse (LVN B) stated she had worked in the Red Zone the day before; that it was just her and it was too much. LVN B stated she recently worked with an RN, but LVN B had to pass the medications for all 27 residents on the Red Zone, so many of the medications were given late. LVN B said this was because the RNs did not have access to PCC (the computer charting system). LVN B also indicated there was a delay in getting an assessment on Resident 7, who was sent out (to the hospital) on [DATE]. LVN B told the surveyor that she did not receive any help from the RNs, and was turning in her resignation. During an interview, on [DATE] at 12:30 PM, Registered Nurse (RN 1) confirmed that the RNs on the Red Zone did not have access to PCC. RN 1 stated they should have been given emergency authorization to have access. She confirmed that the RNs should have been doing resident assessments on paper. During an interview, conducted on [DATE] at 2:30 PM, the Director of Nurses (DON) stated that nursing staff were to assess the health status of residents who tested positive for COVID-19 daily. During an interview, on [DATE] at 5 PM, the staff member responsible for Medical Records (MR) stated she had given Surveyors copies of all the documents requested that day. She confirmed that if a requested documented was not among the copies provided, the facility did not have it in the medical records. When asked to clarify, MR stated she had been asked to provide documents that included all the nursing assessments for each resident, while they were on the Red Zone due to being diagnosed as COVID-19-positive. During an interview, on [DATE] at 10:20 AM, LVN C stated she had been recently completed a month of shifts in the Red Zone. She stated there usually was no RN on the Red Zone. When there was, it was helpful when they would assess the residents and complete the assessment documentation on the paper form entitled, COVID-19 Q Shift Monitoring. LVN C stated the facility expectation was that nursing would complete one of the assessment forms on each resident each shift. She stated the Red Zone was staffed in 12-hour shifts, and should have two assessment forms per resident each day. During an interview, and concurrent record review, on [DATE] at 1:45 PM, MR reviewed with the surveyors the documents that she had copied from the medical records for each of the sampled residents, and compared it to the list of documents requested by the surveyors on [DATE]. As it appeared that much of the requested nursing assessment documentation was not among the provided documents, MR was asked if she had understood the request for nursing assessments. She stated she had, and confirmed that she had provided everything she could find in the medical records for each sampled resident. MR stated that if something was not among the provided documents, then it did not exist. When asked to clarify, she confirmed it should be assumed that a missing nursing assessment indicated that an assessment had not been completed. MR stated, If you're looking for the COVID-19 Q Shift Monitoring paperwork and it's not in the stuff I gave you, then it wasn't done.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to meet the needs of COVID-positive residents when it did not consistently staff the COVID Unit (Red Zone) with Registered Nurses (RNs), whose scope of practice and training exceeds that of Licensed Vocational Nurses (LVNs). RNs are required to participate in direct care in order to conduct comprehensive physical assessments, establish nursing [DIAGNOSES REDACTED]. The failure had the potential to prevent timely, thorough and accurate recognition of, and response to, any life-threatening decline in the health status of a COVID-positive resident on the Red Zone. Findings: A review of a facility policy, titled, Change of Condition Notification, revised ,[DATE], indicated that physicians would be informed of changes in condition in a timely manner. This would include significant changes in a resident's physical, mental or psychosocial status or having to do with a significant change in treatment. Licensed nursing would be responsible to assess for deterioration in health and determine what nursing interventions would be appropriate. Nurses would document their assessments along with the date and time and pertinent details. Further review of the, Change of Condition Notification policy indicated the facility failed to describe the differences in the responsibilities and scope of practice between RNs and LVNs, and the importance and impact of those differences in patient care, as outlined by the California Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians. A review of a California Board of Registered Nursing document titled, NPR-B-03 ,[DATE] - An Explanation of Scope of RN Practice Including Standardized Procedures, revised ,[DATE], indicated that Registered Nurses had the scientific knowledge and technical skill required to helped people cope with and treat their health problems. RNs were responsible for, direct and indirect patient care services that ensure the safety, comfort, personal hygiene and protection of patients, and the performance of disease prevention and restorative measures. RN services included, delegation and supervision of patient care activities performed by subordinates. A review of the California Nursing Practice Act, enacted [DATE], indicated that an RN was authorized to observe for, .signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition and determination of whether these exhibit abnormal characteristics; and based on this determination, the implementation of appropriate reporting or referral, or the initiation of emergency procedures. These independent nursing functions have long been an important focus of nursing education, and an implied responsibility of the registered nurse. Further review of the California Nursing Practice Act indicated that a health facility would not assign licensed personnel to perform nursing functions without direct clinical supervision of an RN, where those functions would require a substantial amount of scientific knowledge and technical skills, including assessment of patient (resident) condition. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Vocational Nursing Practice Act With Rules and Regulations, which included amendments through [DATE], indicated that an LVN may practice basic assessment (data collection), participate in planning, and contribute to evaluation of interventions. Further online review of California nursing scope-of-practice guidelines indicated that an RN would be responsible for conducting a thorough (formal) resident assessment at the beginning of each shift and coordinating care based on particular concerns. An LVN would then perform focused assessments (an assessment in a particular area that might be of concern) and report changes to the RN or to a physician. An RN would be responsible for conducting critical assessments for residents who were acutely ill (in danger of significant illness, injury or death), and LVNs would be responsible for conducting assessments in stable (no decline in health status) residents. Concurrent review of a Board of Vocational Nursing and Psychiatric Technicians document, titled, NPR-I-12 RN As Supervisor, revised ,[DATE], indicated that an LVN must be under the supervision of an RN at all times. Further review indicated that RNs have the responsibility, to supervise care provided by subordinates and to use judgment in delegating functions to them. An RN would fail in their responsibility if they delegated tasks beyond the competence of a worker, delegated functions outside the legal scope of practice of a worker, or failed to assume responsibility when a worker questioned the appropriateness of care to be provided. A review of an webpage document, titled, Licensees, on the Board of Vocational Nursing and Psychiatric Technicians website, as of [DATE], indicated that an LVN was, an entry-level health care provider who is responsible for rendering basic nursing care. A vocational nurse practices under the direction of a physician or registered nurse. A review of facility staffing schedules and sign-in sheets, Master Daily Roster sheets from Nursing Corps (NC), staffing schedules for Registry RNs, and facility Nursing Staffing Information forms, covering September through [DATE], indicated that RNs worked the following schedules, but otherwise did not work on the Yellow and Red Zones: Yellow Zone / Day Shift: [DATE], 3, 7, 8, 9, 10, 14, 15, 16, 17, 22, 26, 28, 29, 30, [DATE], and 5. Yellow Zone / Afternoon shift: [DATE]. Yellow Zone / Night shift: [DATE]. Red Zone / Day shift: [DATE], 27, 29, [DATE], 6, and 7. Red Zone / Night shift: [DATE], 29, [DATE], 8, 9, and 10. A review of a facility line list for COVID-positive residents indicated that most tested positive on [DATE] or [DATE]. A review of Progress Notes, for a sample of twenty-two residents, indicated that most residents were moved to the Red Zone as soon as the facility was notified that they were COVID-positive; usually within two to three days. Therefore, a review of RN staffing on the Red Zone from [DATE] to [DATE], indicated that RN coverage was not provided on 19 out of 30 days, and of the remaining 11 days only five had an RN on both day and night shifts. Further review of the facility staffing schedules indicated that the Red Zone had an AM (day) shift and a PM (night) shift, each 12-hours long. Therefore, from [DATE] through [DATE], there were 25 shifts with no RNs provided. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a Centers for Disease Control online document, titled, Coronavirus Disease 2019 (COVID-19), on [DATE], indicated that as people got older, their risk for severe illness from COVID-19 increased. People in their 60s or 70s are, in general, at higher risk for severe illness .(and) .the greatest risk for severe illness from COVID-19 is among those aged 85 or older. The document also indicated that eight out of ten reported COVID-19-related deaths have been adults ages 65 and older. Further review of the CDC document indicated, There are also other factors that can increase .risk for severe illness, such as having underlying medical conditions. The document indicated that the following were included among underlying medical conditions that placed people at higher risk for death related to COVID-19: cancer, kidney disease, [MEDICAL CONDITIONS], diabetes, and heart conditions. A review of a facility policy, titled, Progress Notes, revised ,[DATE], indicated that all disciplines at the facility would document progress notes in the appropriate section of the resident's medical record according to professional standards and regulations. Progress notes would reflect the resident's current status, progress or lack of progress, changes in condition and other relevant information. All progress notes must be signed with the writer's name and title and are to be documented in a timely manner. A review of Progress Notes and COVID-19 nursing assessment forms (Admission Note - COVID-19 and COVID-19 Q Shift Monitoring forms), for Residents 1 through 16, from the time they tested positive for COVID-19 until they died or were transferred to a hospital, indicated that the facility had a combined 47 days where nursing did not document progress notes per facility policy, and a combined 84 shifts where nursing did not complete COVID-19 assessments. (Refer to F-641, a F-842) During an interview on [DATE] at 9:50 AM, Corporate RN (RN 2) stated the facility would like to have more nursing. She stated they do not have daily RN coverage aside from Management. During an interview, on [DATE] at 10 AM, Staffing Coordinator (SC) stated she had overseen staffing for only 10 days. She had been busy trying to find staff to cover the gaps in the schedule left by so many staff being at home on quarantine for COVID-19. SC stated the facility did not have RNs working every day and could not describe a plan to ensure adequate coverage. SC confirmed that the Corporate nurses, RN 2 and RN 3 had not been scheduled or used to provide direct patient care in the Yellow or Red Zones (the Red Zone included COVID-19-positive residents and the Yellow Zone were all others). During an interview, on [DATE] at 11:45 AM, DON stated the facility has not been able to provide daily coverage with RNs and has not been able to do so for a long time. She stated they would like to be able to provide more RNs to the Red Zone. When asked, DON confirmed they should have an RN available in the Red Zone to assess for COVID complications in order to intervene in an appropriate and timely manner. DON stated, Scheduling is a nightmare. I certainly would not want to do it. During an interview, on [DATE] at noon, Admin stated they were diligently trying to find more RN staffing. Their RN Manager quit suddenly due to the pressures of COVID care. Admin stated they had not been able to find anyone yet. When asked, Admin confirmed it would be necessary to have an RN in the Red Zone to do resident assessments for changes in condition. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 1:20 PM, LVN A stated she was usually assigned to the COVID unit (Red Zone). She stated it was hectic there and there was usually no RN to back them up. LVN A stated she had often asked for more help in the Red Zone as the residents there were acute (a level of illness that required close attention and frequent care). She stated a resident had recently coded (required CPR) on the Red Zone and she could have used an RN's assistance. LVN A stated the nurses on Red Zone were, stressed, overloaded, and tapped-out. She stated the nurses on the Red Zone are unable to take breaks or an uninterrupted lunch break when there is only one licensed nurse on the unit. During an interview, on [DATE] at 2:45 PM, CNA 2 stated she had worked there about four years. She stated during that time they often work without an RN present. She said an example of this was that they were working that day on the Yellow Zone with half the staff they should have and that they did not have an RN. She stated, Many days there is not an RN. During an interview on [DATE] at 12:15 PM, Licensed Nurse (LVN B) stated she had worked in the Red Zone the day before; that it was just her and it was too much. LVN B stated she recently worked with an RN, but LVN B had to pass the medications for all 27 residents on the Red Zone, so many of the medications were given late. LVN B said this was because the RNs did not have access to the computer charting system. During an interview, on [DATE] at noon, the previous Staffing Coordinator (PSC) stated the facility did not have any registered nurses on staff. She stated they needed to have better RN coverage. PSC stated they needed to get RNs specifically for the Red Zone, even though that would leave them unavailable for the rest of the building. PSC stated that RN 2, and, RN 3 had not provided direct patient care that she was aware of. She stated that DON had possibly provided some element of direct care once or twice. During an interview conducted on [DATE] at 2:30 PM, the Director of Nurses (DON), she stated that nursing staff were to assess the health status of residents who tested positive for COVID-19 daily.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that 16 of 16 (Residents ,[DATE]) sampled residents had complete and accurate medical records, and that the facility's medical records could be easily accessed upon request. This failure had the potential to create incomplete medical histories, and assessments which could lead to poor coordination of care and services. Findings: 1. During a survey of the facility on [DATE], between 9:50 AM and 11:50 AM, the facility was unable to provide two surveyors with functional access to the electronic medical records (EMR). By 5 PM, only one of two surveyors had been given functional access to the EMR, but it kept kicking them out of the system, and required Medical Records to produce paper copies of the documents the surveyors needed to review. A review of a facility policy, titled, Progress Notes, revised ,[DATE], indicated that all disciplines at the facility would document progress notes in the appropriate section of the resident's medical record according to professional standards and regulations. Progress notes would reflect the resident's current status, progress or lack of progress, changes in condition, and other relevant information. All progress notes must be signed with the writer's name, title, and are to be documented in a timely manner. 2. A review of Progress Notes, and COVID-19 nursing assessment forms (Admission Note-COVID-19, and COVID-19 Q (every) Shift Monitoring forms), for Residents 1 through 16, from the time they tested positive for COVID-19, until they died , or were transferred to a hospital, indicated that the facility had a combined 47-days where nursing did not document progress notes per facility policy, and a combined 84-shifts where nursing did not complete COVID-19 specific assessments. Resident 1's record was reviewed, and indicated that they were admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Progress Notes, indicated that nursing staff did not complete assessments of Resident 1's health status on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], and [DATE]. Resident 2's record was reviewed, indicated that they had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of Resident 2's Progress Notes indicated that nursing staff did not complete assessments of Resident 2's health status on ,[DATE], and [DATE]. Resident 3's record was reviewed, and indicated that they had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 3's Progress Notes indicated that nursing staff did not complete assessments of Resident 3's health status on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], and [DATE]. Resident 4's record was reviewed, and indicated that they had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 4's Progress Notes indicated that nursing staff did not complete assessments of Resident 4's health status on ,[DATE], ,[DATE], and [DATE]. Resident 5's record was reviewed, and indicated that they had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 5's Progress Notes indicated that nursing staff did not complete assessments of Resident 5's health status on ,[DATE]/, ,[DATE], ,[DATE], ,[DATE], ,[DATE], and [DATE]. Resident 6's record was reviewed, and indicated that they had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 6's Progress Notes indicated that nursing staff did not complete assessments of Resident 6's health status on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], and [DATE]. Resident 7's medical record was reviewed, and indicated that they had been admitted [DATE], with [DIAGNOSES REDACTED]. A review of Resident 7's Progress Notes indicated that from [DATE] to [DATE], and from [DATE] to [DATE], nurses did not document an assessment for Resident 7. A review of a paper COVID-19 assessments required each shift indicated that for Resident 7, on night shift [DATE], the nurse did not complete the resident identifying information on each form, did not sign or date the form, did not document in the required spot that Resident 7 was on the high-risk medication [MEDICATION NAME] ([MEDICATION NAME]), and did not document in the required spot that Resident 7 had been started on [MEDICAL CONDITION] therapy ([MEDICATION NAME]). Further review indicated the nurse noted a change in lung sounds (rales: rattling sound in lungs related to secretions), but there was no indication on the paper form, or in computer Progress Notes that the doctor was notified. Further review indicated that there was no paper COVID assessment done for Resident 7 on day shift on [DATE]. A review of a paper COVID-19 assessment for Resident 7, done on the night shift of [DATE], indicated the nurse did not complete the resident identifying information on each form, did not sign or date the form, and did not indicate that Resident 7 was on the high-risk medication, or [MEDICAL CONDITION] therapy. Further review indicated the nurse noted the lung sounds still had rales, but there is no indication on the paper form, or in computer notes that the doctor was notified that the lungs were no longer clear. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a paper COVID assessment for Resident 7, done on day shift [DATE], indicated the nurse did not document any of Resident 7's vital signs, or that she was on a high-risk blood-thinning medication, or [MEDICAL CONDITION] therapy. The nurse indicated that Resident 7 complained of losing her sense of smell and taste, and had an episode of vomiting, but there was no indication on the paper form or in computer that the doctor was notified of these changes in Resident 7's condition. A review of a paper COVID assessment for Resident 7, done on night shift [DATE], indicated the nurse did not document four out of five vital signs, did not complete the resident's identifying information, did not sign or date the form, did not indicate Resident 7 was on a high-risk blood-thinning medication, or [MEDICAL CONDITION] therapy. The form indicated Resident 7 had shallow respirations, diminished lung sounds, and a non-productive cough, but there was no indication on the paper form or in computer that the doctor was notified of these changes in Resident 7's condition. Further review, indicated that there was no paper COVID assessment done for Resident 7 on night shift [DATE]. A review of a paper COVID assessment for Resident 7, done on day shift [DATE], indicated the nurse did not sign and date the form, did not complete the necessary resident identifying information, and did not document in the required sections that Resident 7 was now on two high-risk blood thinning medications ([MEDICATION NAME], and [MEDICATION NAME]) and on [MEDICAL CONDITION] therapy. Further review, indicated that there was no paper COVID assessment done for Resident 7 on night shift [DATE]. A review of a paper COVID assessment for Resident 7, done on day shift [DATE], indicated the nurse did not document resident 7's vital signs. The form was missing two pages, and had no signature. A review of a paper COVID assessment for Resident 7, done on night shift [DATE], indicated the nurse did not document resident 7's identifying information on two of three pages, did not sign and date the form, and did not document that Resident 7 was on [MEDICAL CONDITION] therapy, or on [MEDICATION NAME]. A review of a paper COVID assessment for Resident 7, timed from 6 PM to 6 AM, is lacking the date on the form, Resident 7's vital signs, her identifying information on two of three pages, lacks documentation about [MEDICAL CONDITION] therapy, and is not signed. Further review, indicated that there was no paper COVID assessment done for Resident 7 on day and night shifts [DATE], on day and night shifts [DATE], or on day shift [DATE]. A review of a paper COVID assessment for Resident 7, done on night shift [DATE], indicated the nurse did not document resident 7's vital signs. The form was missing two pages and has no signature. A review of a paper COVID assessment for Resident 7, dated for night shift [DATE], was signed and dated as [DATE]. It lacked Resident 7's vital signs, identifying information on two pages, skipped several sections of assessment, and contained no meaningful documentation about Resident 7 being on [MEDICAL CONDITION] therapy, or two blood-thinners. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review, indicated that there was no paper COVID assessment done for Resident 7 on day or night shifts on [DATE], or on the day shift of [DATE]. A review of a paper COVID assessment for Resident 7, dated for night shift [DATE], did not include the entire second page of assessments, and did not include a blood pressure recording. Further review, indicated that there was no paper COVID assessment done for Resident 7 on day or night shifts on [DATE]. A review, of Resident 7's medical record indicated she was transferred to the hospital on [DATE]. Resident 8's medical record was reviewed, and indicated that they had been admitted [DATE], with [DIAGNOSES REDACTED]. Resident 8 was transferred to the hospital on [DATE], where he subsequently died . A review of COVID-19 Q Shift Monitoring assessment forms for Resident 8, from ,[DATE] to [DATE], indicated that forms were not completed for the ,[DATE] afternoon and night shift, for any shifts on ,[DATE], and ,[DATE], or for the [DATE] night shift. Resident 9's medical record was reviewed, and indicated that they had been admitted [DATE], with [DIAGNOSES REDACTED]. A review of Progress Notes for [DATE], indicated the facility was notified that Resident 9 was positive for COVID-19. A review of a Census List record showing room changes indicated Resident 9 was moved to the Red Zone on [DATE]. A review of COVID-19 Q Shift Monitoring assessment forms for Resident 9, from ,[DATE] to [DATE], indicated that forms were not completed for ,[DATE] night shift, for any shifts on ,[DATE], and ,[DATE], for , [DATE], night shift, for any shifts ,[DATE] through [DATE]. Resident 10's record was reviewed, and indicated that they had been admitted on [DATE], with [DIAGNOSES REDACTED]. A review of COVID-19 Q Shift Monitoring assessment forms for Resident 10, from ,[DATE] to [DATE], indicated that no assessment forms were completed on the ,[DATE] morning and night shifts, ,[DATE] night shift, or any shifts on ,[DATE] through [DATE]. A review of medical records for Resident 10 indicated there was no Progress Notes documented by nursing on [DATE]. Resident 11's medical record was reviewed, and indicated that they had been readmitted on [DATE], from the hospital with [DIAGNOSES REDACTED]. Further review of Progress Notes for Resident 11 indicated nursing did not complete a progress note on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of COVID-19 Q Shift Monitoring assessment forms for Resident 11, from ,[DATE] to [DATE], indicated that no assessment forms were completed during the time frame of being COVID-positive. Further review of the records the facility provided indicated that no such assessment forms were completed for Resident 11 after the morning shift on [DATE], through to hospitalization . Resident 12's medical record was reviewed, and indicated that they had been admitted on [DATE], with [DIAGNOSES REDACTED]. Further review of Progress Notes for Resident 12 indicated nursing did not complete a progress note on [DATE]. A review of COVID-19 Q Shift Monitoring assessment forms for Resident 12, indicated that none were completed after night shift on [DATE], through to hospitalization . Resident 13's record was reviewed, and indicated that they had been admitted on [DATE], with [DIAGNOSES REDACTED]. Further review of Progress Notes indicated that nursing did not document any Progress notes for Resident 13 on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], and [DATE]. Resident 14's medical record was reviewed, and indicated that they had been admitted on [DATE], with [DIAGNOSES REDACTED]. Further review of Progress Notes for Resident 14 for the month of ,[DATE], indicated that no nursing Progress Notes were written from [DATE] through [DATE]. There were no Progress Notes during that time frame to indicate if Resident 14 had been transferred elsewhere. No COVID-19 Q Shift Monitoring nursing assessments, requested for review from ,[DATE] through ,[DATE], were provided by the facility for review. During an interview on [DATE] at 1:45 PM, with Medical Records staff, she confirmed that the assessments were not completed by nursing. Resident 15's was reviewed, and indicated that they had been admitted [DATE], with [DIAGNOSES REDACTED]. A review of Progress Notes, dated [DATE], indicated Resident 15 was transferred to the hospital due to critical decline in kidney function. A review of COVID-19 Q Shift Monitoring nursing assessments for Resident 15, requested for review from [DATE] through [DATE], indicated that the following nursing assessments were not done on the ,[DATE], morning and night shifts, ,[DATE] all shifts, ,[DATE] all shifts, and [DATE] morning, and afternoon shifts. Resident 16's medical record was reviewed, and indicated that they had been admitted on [DATE], with [DIAGNOSES REDACTED]. Further review of Progress Notes for Resident 16, from [DATE] to [DATE], indicated that nursing did not document Progress Notes on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of COVID-19 Q Shift Monitoring nursing assessments of Resident 16, from ,[DATE] to [DATE], indicated that nursing did not do assessments for any shifts on those dates. During an interview, on [DATE] at 5 PM, the staff member responsible for Medical Records (MR) stated she had given Surveyors copies of all the documents requested that day. She confirmed that if a requested documented was not among the copies provided, the facility did not have it in the medical records. When asked to clarify, MR stated she had been asked to provide documents that included all the nursing assessments for each resident, while they were on the Red Zone due to being diagnosed as COVID-19-positive. During an interview, and concurrent record review, on [DATE] at 1:45 PM, MR reviewed with the surveyors the documents that she had copied from the medical records for each of the sampled residents, and compared it to the list of documents requested by the surveyors on [DATE]. As it appeared that much of the requested nursing assessment documentation was not among the provided documents, MR was asked if she had understood the request for nursing assessments. She stated she had, and confirmed that she had provided everything she could find in the medical records for each sampled resident. MR stated that if something was not among the provided documents, then it did not exist. When asked to clarify, she confirmed it should be assumed that a missing nursing assessment indicated that an assessment had not been completed. MR stated, If you're looking for the COVID-19 Q Shift Monitoring paperwork and it's not in the stuff I gave you, then it wasn't done.