

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 555214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/03/2020
NAME OF PROVIDER OF SUPPLIER PROFESSIONAL POST ACUTE CENTER		STREET ADDRESS, CITY, STATE, ZIP 81 PROFESSIONAL CENTER PARKWAY SAN RAFAEL, CA 94903	
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 0695 Level of harm - Immediate jeopardy Residents Affected - Few	<p>Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, interview and record review, the facility failed to provide respiratory care consistent with physicians' orders and professional standards of practice and failed to have a policy and procedure for oxygen administration for five of five residents (Residents 1, 2, 3, 4 and 5) when: 1) For Resident 1, who had COVID-19 (a [MEDICAL CONDITION] respiratory illness causing severe respiratory distress) and had a physician's orders [REDACTED]. saturation levels every shift to ensure oxygen saturation levels of at least 90%; b) did not provide Resident 1 with oxygen per physician's orders [REDACTED]. facemask attached to a reservoir oxygen bag connected to an external oxygen tank used to deliver higher concentrations of oxygen of at least 10 liters per minute) without a physician's orders [REDACTED]. These failures could have resulted in Resident 1's death. Because of the risk of death for Resident 1 from the failure to administer oxygen per physician's orders [REDACTED], presence of the Administrator and the DON, after verification of implementation of the U removal plan. 2) For Residents 2, 3, 4 and 5, who also had orders for oxygen, the facility failed to monitor their oxygen saturation levels at least once every shift and failed to have a policy and procedure for oxygen administration. These failures had the potential for Residents 2, 3, 4 and 5 not to receive oxygen and maintain adequate oxygen saturation levels per physicians' orders. Findings: 1) A review of Resident 1's Admission Record, printed on [DATE] at 1:32 p.m., indicated Resident 1 was admitted to the facility on [DATE]. A review of the facility's census (a list of all residents in the facility and their room numbers), for [DATE], indicated Resident 1's room was located in the facility's red area (for residents with COVID-19). During an interview on [DATE], at 10:40 a.m., the Administrator stated the facility had been divided into three color-coded areas: the red area housed residents who had a confirmed [DIAGNOSES REDACTED]. COVID-19 is an infectious disease that affects the lungs and causes shortness of breath and difficulty breathing. Other symptoms includes cough, fever, headache, loss of taste and smell, shaking and chills, sore throat and muscle pain. These symptoms range from mild to severe and can cause death. The risk for severe symptoms and death increases with age. The greatest risk of death is for people aged 85 or older. treatment for [REDACTED]. (https://coronavirus.dc.gov/page/what-covid-19) (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html) (https://www.covid19treatmentguidelines.nih.gov/) During an observation on [DATE], at 1:15 p.m., Resident 1 was lying in bed in her room. Resident 1 had labored breathing and was wearing a nasal cannula connected to a portable oxygen tank with the oxygen level gauge in the tank indicating 0 (zero) oxygen. The state surveyor informed Licensed Nurse A who sent Certified Nursing Assistant (CNA) B to check on Resident 1. CNA B went into Resident 1's room and stated Resident 1's oxygen tank was empty. CNA B stated Resident 1 was supposed to be on oxygen. CNA B measured Resident 1's oxygen saturation using a pulse oximeter (a small device that slides over the fingertips and measures the level of oxygen in the blood) and stated Resident 1's oxygen saturation was 83%. Normal oxygen saturation levels measured by pulse oximetry are between [DATE]%. Oxygen saturation levels lower than 90% indicate hypoxemia (abnormally low levels of oxygen in the blood). Oxygen saturation levels lower than 85% indicate severe hypoxemia. (www.ncbi.nlm.nih.gov/pmc/articles/PMC15) Hypoxemia has been associated with death in patients diagnosed with [REDACTED].org/10.1016/j.mayocp.2020.04.006 / www.mayoclinicproceedings.org) Professional standards of nursing practice indicate that residents receiving oxygen therapy require regular and frequent monitoring to ensure safe administration of oxygen. (Lippincott Manual of Nursing Practice, 9th Edition, Wolters, Kluwer Health, 2010, p. 245). During an interview on [DATE], at 1:40 p.m., the Director of Nursing (DON) stated Resident 1 had COVID-19 and confirmed Resident 1 was receiving supplemental oxygen per physician's orders [REDACTED]. A review of the Order Summary Report, dated [DATE], indicated the following physician's orders [REDACTED]. @ 2 liter/min (minutes) via Nasal Cannula continuous for O2 (oxygen) sat (saturation) below 90% on RA (room air). During an observation on [DATE], at 1:50 p.m., Licensed Nurse C was in Resident 1's room checking Resident 1's vital signs. Licensed Nurse C stated Resident 1's oxygen saturation was 82%. Licensed Nurse C stated Resident 1 had run out of supplemental oxygen. A review of Resident 1's care plans (documents instructing staff on how to care for the resident), undated but provided by the facility during the survey, indicated no care plan or interventions for monitoring Resident 1's oxygen saturation or the functioning of oxygen equipment for Resident 1. During an interview on [DATE], at 3:40 p.m., the DON was asked for the facility's policy for monitoring residents receiving oxygen, including oxygen saturation. The DON stated the facility's policy was for residents to have a full set of vital signs taken once every shift (8 hours), which included oxygen saturation. The DON stated the oxygen saturation values were recorded in the residents' charts. The DON was asked for a written copy of this policy and stated she would look for it. During an interview on [DATE], at 3:40 p.m., the DON was asked for a copy of Resident 1's oxygen saturation measurements. The DON provided a copy of document titled O2 Sats Summary for Resident 1. A review of the O2 Sats Summary indicated the most recent oxygen saturation level for Resident 1 was dated two days prior, on [DATE], at 2:46 p.m., and indicated 90% and Oxygen via Nasal Cannula. The second most recent documented oxygen measurement saturation for Resident 1 was dated [DATE], at 2:30 p.m., and indicated 78% and Room Air (not on oxygen). The third most recent documented oxygen measurement saturation for Resident 1 was dated more than a month before, on [DATE], at 10:18 p.m., and indicated 96% and Room Air. During an observation on [DATE], at 4:15 p.m., Resident 1 was lying in bed in her room. Resident 1 had labored breathing and was wearing a non-rebreather oxygen mask connected to a portable oxygen tank set at a rate of six liters per minute. During a concurrent interview, Licensed Nurse C was asked if Resident 1 had a physician's orders [REDACTED]. Licensed Nurse C stated no. Licensed Nurse C stated that another nurse, Licensed Nurse D, called Resident 1's physician who told Licensed Nurse D to make Resident 1 comfortable, but stated no new oxygen orders were given. A non-rebreather oxygen mask uses an oxygen reservoir bag attached to the mask and connected to an oxygen source to deliver high concentrations of oxygen. Non-rebreather oxygen masks must be used with a high oxygen flowrate of at least 10 liters per minute and must be used cautiously by experienced medical staff (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC77) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC35). According to professional standards of practice, the administration of oxygen therapy requires a physician's orders [REDACTED]. It should be treated like any other drug; it should be prescribed in writing, with the required flow rate and the method of delivery clearly specified. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC09/). Oxygen is . considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . This standard procedure helps prevent incidence of misuse or oxygen deprivation which could worsen the patients [MEDICAL CONDITION] and ultimate outcome. (https://pubmed.ncbi.nlm.nih.gov/391/). During an observation on [DATE], at 4:40 p.m., Resident 1 was lying in bed in her room. Resident 1 was wearing a non-rebreather oxygen mask with the oxygen reservoir bag deflated (indicating no oxygen was available) connected to a portable oxygen tank with the oxygen level gauge reading 0 (zero) oxygen. There were no staff in Resident 1's room. The application of an oxygen mask without proper oxygen flow can result in death: Never apply an oxygen mask on the patient without supplemental oxygen flowing; this results in the patient re-breathing their own CO2 (carbon [MEDICATION NAME] - an asphyxiating gas), acidosis (high level of acid in the body), [MEDICAL CONDITION] (lack of oxygen in</p>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE		(X6) DATE

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.

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F 0695 Level of harm - Immediate jeopardy Residents Affected - Few	<p>(continued... from page 1)</p> <p>cells and tissues) and possible death. (Los Angeles Medical Services Agency - Los Angeles County. Breathing Emergency - Oxygen Delivery, undated, available at www.lacounty.gov). During an interview on [DATE], at 4:50 p.m., the DON confirmed the facility did not have a policy and procedure for oxygen administration. 2) During an interview on [DATE], at 3:40 p.m., the DON stated there were four additional residents with physicians' orders for supplemental oxygen: Residents 2, 3, 4 and 5 and provided document titled Order Listing Report, dated [DATE], which contained the physicians' orders for oxygen. A review of the Order Listing Report, dated [DATE], indicated the following physicians' orders: Resident 2: active order dated [DATE] for Oxygen @ 2 liter/min (liters per minute) via Nasal Cannula continuously Dx (diagnosis). Resident 3: active order dated [DATE] for Oxygen 2L/min (liters per minute) via nc (nasal cannula) to keep saturation > (above) 92%. Resident 4: active order dated [DATE] for Oxygen @ .[DATE] liter/min (liters per minute) via Nasal Cannula Dx. Chronic [MEDICAL CONDITION]. Resident 5: active order dated [DATE] for Start Oxygen 2L/min via nasal cannula to keep saturation > (above) 92%. During an interview on [DATE], at 3:40 p.m., the DON was asked for records of the monitoring of oxygen saturation levels of Residents 2, 3, 4 and 5 and provided document titled Weights and Vital Summary dated [DATE] for Residents 2, 3 and 4. No records were provided for Resident 5. A review of the Weights and Vital Summary dated [DATE] for Residents 2, 3 and 4, for the previous seven days, indicated the facility did not monitor oxygen saturation levels daily or every shift, as follows: Resident 2: oxygen saturation monitored on [DATE] at 3:17 p.m., [DATE] at 7:37 p.m., [DATE] at 5:41 p.m., [DATE] at 10:19 a.m.; [DATE] at 2:34 a.m.; [DATE] at 9 a.m.; [DATE] at 3:19 a.m., [DATE] at 10:25 p.m. Resident 3: oxygen saturation monitored on [DATE] at 1:26 a.m., [DATE] at 2:28 p.m., [DATE] at midnight, [DATE] at 2:26 a.m., [DATE] at 4:36 a.m., 2 p.m., 2:24 p.m., 8:06 p.m. and 8:07 p.m. Resident 4: oxygen saturation monitored on [DATE] at 1:26 a.m. and at [DATE] at 2:26 a.m. Resident 5: no records provided. A review of the facility census for [DATE] indicated Resident 2 was in the red area (for residents positive with COVID-19), and Residents 3, 4 and 5 were in the yellow area (for residents who initially tested positive for COVID-19 but now had tested negative but were still showing symptoms of COVID-19). The Centers for Medicare and Medicaid standard is for the monitoring of oxygen saturation three times per day for residents of skilled nursing facility residents with COVID-19 or who are showing symptoms of the disease (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html). Professional standards of nursing practice indicate that for patients receiving supplemental oxygen via nasal cannula nurses should assess the patient's condition, ABG (arterial blood gas - a measurement of gasses in the blood) or SaO2 (oxygen saturation) and the functioning of equipment at regular intervals (Lippincott Manual of Nursing Practice, 9th Edition, Wolters, Kluwer Health, 2010, p. 245). The medical literature indicates the need for careful monitoring of patients receiving supplemental oxygen: Like any drug there are clear indications for treatment with oxygen and appropriate methods of delivery. Vigilant monitoring to detect and correct adverse effects swiftly is essential. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC09) During an interview on [DATE], at 4:50 p.m., the DON confirmed the facility did not have a policy and procedure for oxygen administration.</p>		
F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections when the facility's commercial trash bin was overflowing and there was trash scattered around the facility. This failure created an unsanitary environment for residents and the potential for spreading infectious diseases. Findings: During an observation on 8/3/20 at 10 a.m., the facility commercial trash bin located in the front of the facility, left of the parking garage, was overflowing with trash. The lid to the trash bin was wide open due to the trash was piled high. There were multiple full garbage bags on the ground right of the garbage bin and there was an abundance of loose trash on the ground located left of the trash bin. There were multiple disposable used gloves and a used surgical mask tossed in the flower/shrub beds and on the pathways near the front entrance to the facility, and leading to the side entrance, which led to the Person Under Investigation (PUI) for COVID-19 hallway. There was a pile of disposable used gloves, which had been swept in a corner, left of the front entrance to the facility. During an observation and interview on 8/3/20 at 10:05 a.m., the Director of Nursing (DON) was shown the gloves and mask tossed in the front flower/shrub beds and on the pathways. The DON stated the disposable gloves and mask were not supposed to be disposed of outside the building. The DON stated this was an infection control issue. During an observation and interview on 8/3/20 at 10:20 a.m., the DON showed the Housekeeping Assistant Manager the used surgical mask and the used disposable gloves tossed in the front flower/shrub beds and pathways. The DON showed Housekeeping Assistant Manager the pile of used disposable gloves swept in a corner, left of the front entrance to the facility. The Housekeeping Assistant Manager stated there was a need for more waste bins for the outside; there was a shortage. Both the DON and the Housekeeping Assistant Manager stated the staff disposing of used PPE (Personal Protective Equipment) outside the facility was an infection control issue. The DON stated after the HCP (Healthcare Personal) was finished caring for a COVID resident or a PUI, used disposable gloves should be disposed of in a waste bin, located in the resident's room, and the HCP's mask should be disposed of in a waste bin before leaving the COVID or PUI hallway. The DON stated transmission based precautions were not being followed for COVID-19. During an interview on 8/3/20 at 11:20 a.m., the Administrator stated the waste management company picked up the facility's trash four times per week, and were not due to pick-up the trash until tomorrow. The Administrator stated overflowing waste bins did not look good/clean for the surrounding environment, and was an infection control issue.</p>		