DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555459	A. BUILDING _____ B. WING _____ received 11/17/16 LD	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAMERCY COURT	2200 GRAMERCY DRIVE SACRAMENTO, CA 95825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00487933. Representing the Department of Public Health: HFEN, 26663 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record and facility policy review, the facility failed to ensure 1 of 3 sampled residents (Resident 1) was not subjected to abuse when Resident 1 was neglected for more than 1.5 hours when requesting to be cleaned of feces. This failure had the potential to result in skin breakdown, and frustration. Findings: Resident 1 was admitted to the facility in 2016	F 224	**How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ▪ Resident no longer in facility. ▪ Alleged CNA was terminated on 5/18/16. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ DON/ADON/Social Services interviewed current residents to any additional care concerns. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ▪ Staff education occurred by DON, ADON and DSD on 9/30/16 regarding timely care expectations and abuse training. **How the facility plans to monitor its performance to make sure solutions are sustained:** • DON/designee will conduct a random audit of five residents a week to question on if there are any care concerns or any unreported abuse allegations. Results of audits will be forwarded to QA until three consecutive months of 100% compliance is obtained.	10/11/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/11/16

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 224	Continued From page 1 with diagnoses which included paralysis of his legs. Review of the clinical record for Resident 1 revealed: An MDS (minimum data set, an assessment tool) dated 5/20/16, that revealed Resident 1 did not have cognitive impairment, and was incontinent of bowel and bladder. A 5/12/16 History and Physical progress note documented the resident had the capacity to make decisions and "C Difficile diarrhea." (Clostridium difficile, a bowel infection which caused frequent diarrhea.) A 5/13/16 progress note documented the, "Family was requesting that he be transferred to a new facility due to lack of care given...family had concerns regarding the previous night and the care givers..." In an interview with a family member of Resident 1 (FM 1) on 5/13/16 at 9:50 a.m., FM 1 stated the resident had called her last night, "Very upset and crying because he had been sitting in his own feces for over 1-1/2 hours," and could not get assistance from facility staff. Review of the personnel file for Certified Nurses Assistant 1 (CNA 1) revealed: A 5/18/16 "Notice of Personal Action," form revealed CNA 1's employment had been terminated from the facility on 5/18/16 for misconduct. A typed note, dated 5/17/16, and written by	F 224		

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F 224	Continued From page 2 physical therapist 1 (PT 1) revealed, "On the afternoon of 5/13/16 at approximately 2 pm... [Resident 1] reported to this therapist...that he was very upset from the evening prior....[he] reported that his CNA [CNA 1's name] knowingly left him soiled in his brief for 2.5-3 hours after requesting to be changed on multiple occasions. [Resident 1] also reported that [CNA 1] made an indirect threat stating that, "she keeps razor blades in her mouth...and that he should keep quiet". A printed email communication from the Director of Nurses (DON), dated 5/13/16 included, "[Resident 1] and three family members) have reported that he was left in his bowel movement for about 2-1/2 hours on PM shift. He reported that he repeatedly pressed the call light, and that [CNA 1], would go into his room and turn the light off. It was also reported to me by his family member that the CNA said to the patient that she keeps a razor in her mouth. The family member stated that she takes this as a threat...[PT 1's name] informed me that the same patient told him the exact same story, including the razor in the mouth. He stated the resident was almost in tears." Review of facility policy titled, Resident Abuse Prevention Policy, dated as revised on 10/27/14 directed, "Abuse, neglect, abandonment, isolation, misappropriation of property, or financial abuse will not be tolerated in this facility at any time. Each resident has the right to be free from verbal, mental, physical and sexual abuse..." During an interview with PT 1 on 8/29/16 at 12:06 p.m., PT 1 verified he had written the typed note, dated 5/17/16. PT 1 stated Resident 1 was	F 224		

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F 224	Continued From page 3 cognitively intact and PT 1 was confident the resident's report to him was accurate. PT 1 stated, "She [CNA 1] was negligent."	F 224		