STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056410	A. BUILDING _____ B. WING _____	12/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITNEY OAKS CARE CENTER	3529 WALNUT AVENUE CARMICHAEL, CA 95608

acceptable POC 2/7/18 DF

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification survey. Representing the Department of Public Health: HFEN, 29821 HFEN, 32481 HFEN, 35598 HFEN, 36586 HFEN, 38970 HFEN, 39797 The facility census was 101. The sample size was 26.	F 000	**PLAN OF CORRECTIONS** **"This plan of correction is prepared as part of the quality assurance process for the provider. This plan of correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such are protected from discovery."**	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the safety of 4 of 7 residents (Residents 16, 69, 81 and 87) who smoke when lighters and cigarettes were found in the possession of these four smokers. This failure had the potential to put these residents as well as other residents at risk for harm. Findings:	F 689	**"This plan of correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes, and or guidelines. As this transmission is required by law, it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations."**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Donalwah Dewoph TITLE DO (X6) DATE 2/1/2018

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 689	Continued From page 1 1. Review of the medical record document titled Resident face sheet indicated Resident 87 was admitted to the facility in November of this year. A facility provided list of smokers identified Resident 87 as a smoker. Review of Resident 87's medical record document titled Clinical Observations - Safe Smoking - Risk, dated 11/10/17, indicated Resident 87 had a BIMS (Brief Interview for Mental Status, 15-question evaluation of mental processes including perception, memory, judgment and reasoning; ideal score is 15) of 15/15 and agreed to the facility's smoking policy. This assessment included smoking supervised during scheduled smoking times, required all smokers to wear an apron, and stipulated smoking materials were to be kept secured by staff. Review of Resident 87's medical record document titled Smoking Care Plan indicated Resident 87 does smoke without supervision and preferred to keep his own cigarettes. The goal was identified as "Will smoke in designated areas and will obey smoking policy" with interventions that included to continue to educate and explain risks and consequences of keeping cigarettes with him, to encourage the use of a smoking apron, and to keep his lighter in a secure area. During a concurrent observation and interview on 12/19/17 at 3:38 p.m., a pack of cigarettes and a lighter were observed on Resident 87's bedside table . Resident 87 stated they were his and verified he has them with him at all times. During a follow up interview on 12/21/17 at 3:00	F 689	**F 689** **1. Resident 87 was discharged from the facility on 1/5/2018.** **2. Resident 69 is unsupervised smoker. His smoking assessment and care-plan were updated on 1/9/2018 to reflect he is safe to smoke independently and can use an apron only if desired.** **The facility will provide a safe lock box for resident to keep his smoking paraphernalia secured at his bedside.** **The Activity Director met with the resident to educate him on use of the safety box, smoking policy and locking up his cigarettes and lighter.** **Weekly times 4 weeks and monthly thereafter, the**	

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F 689	Continued From page 2 p.m., Resident 87 stated he has his own lighter and cigarettes and he independently smokes "...whenever I wants [sic]." Resident 87 then showed the Department his cigarettes and lighter, and stated he "does not" wear a smoking apron. 2. Review of the medical record document titled Resident face sheet indicated Resident 69 was admitted to the facility in November 2016 with diagnoses that included heart disease, shortness of breath and asthma. A facility provided list of smokers identified Resident 69 as a smoker. Review of Resident 69's medical record document titled Clinical Observations - Safe Smoking - Risk, dated 11/26/17, indicated Resident 69 had a BIMS of 14/15 and agreed to the facility's smoking policy. This assessment included smoking supervised during scheduled smoking times, required all smokers to wear an apron, and stipulated smoking materials were to be kept secured by staff. Review of Resident 69's medical record document titled Smoking Care Plan indicated Resident 69 does smoke unsupervised and preferred to have his cigarettes in his possession. The goal was identified as "Will smoke in designated areas and will obey smoking policy" with interventions that included continue to educate and explain risks, keep lighters in secured area, encourage to use a smoking apron, monitor resident does not keep their lighter in their possession and review the facility policy and procedure. On 12/22/17 at 11:00 a.m., during a concurrent observation and interview, Resident 69 stated he has his own cigarettes and lighter. Resident 69	F 689	**Activity Director will make rounds to ensure the resident is keeping his lighters in the secured box.** **3. Resident 16 is an independent smoker. His smoking assessment and care-plan were updated on 1/9/2018 to reflect he is safe to smoke independently and can use an apron only if he desired.** **The facility will provide the resident with a safe lock box to lock up his smoking paraphernalia.** **The Activity Director met with the resident to discuss the safe smoking policy and educated him on locking his lighters and cigarettes.** **Weekly times 4 weeks and monthly thereafter, the Activity Director will make rounds to ensure that residents smoking**	

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F 689	Continued From page 3 then showed the Department his cigarettes and lighter. Resident 69 further stated he does not wear a smoking apron while smoking. 3. Review of the medical record document titled Resident face sheet indicated Resident 16 was admitted to the facility in March 2016 with diagnoses that included chronic obstructive pulmonary disease (COPD - a lung disease making breathing difficult), shortness of breath and respiratory failure. A facility provided list of smokers identified Resident 16 as a smoker. Review of Resident 16's medical record document titled Clinical Observations - Safe Smoking - Risk, dated 11/22/17, indicated Resident 16 had a BIMS of 15/15 and agreed to the facility's smoking policy with the exception the smoking schedule. This assessment included agreeing to remove oxygen before smoking, smoking supervised during scheduled smoking times, required all smokers to wear an apron, and stipulated smoking materials were to be kept secured by staff. Review of Resident 16's medical record document titled Smoking Care Plan indicated Resident 16 was sometimes noncompliant with smoking policy by smoking in a non smoking area, refused to surrender cigarettes and preferred to have his cigarettes in his possession. The goal was identified as "Will smoke in designated areas and will practice safe smoking" with interventions that included continue to educate and explain risks, keep lighters in secured area, encourage to use a smoking apron, monitor resident does not keep their lighter in their possession, staff to monitor that oxygen is turned off prior to smoking and to review the	F 689	**paraphernalia is safely secured.** **4. Resident 81's safe smoking assessment and care-plan were updated on 1/9/18. Resident is an independent smoker. His care-plan reflects that he can wear a smoking apron only as he desires.** **The facility will provide the resident with a safe lock box to store his smoking paraphernalia at bedside.** **The Activity Director educated the resident on the safe smoking policy and need to keep his lighter and cigarettes in the secured box.** **Weekly times four weeks and monthly thereafter, the Activity Director will make rounds to ensure lighters and cigarettes are safely secured.**	

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F 689	Continued From page 4 facility policy and procedure. During a concurrent observation and interview on 12/21/17 at 3:49 p.m., observed Residents 81 and 16 on the patio smoking with staff member in line-of-sight. Neither resident was wearing a smoking apron. Both residents stated they keep their cigarettes and lighters at their bedside dressers. During a concurrent observation and interview on 12/22/17 at 11:10 a.m., Resident 16 stated he has his lighter and cigarettes in his right tee shirt pocket and then verified this by pulling the items out of his pocket. Resident 16 is on oxygen via nasal cannula (tubes entering the nostrils). He further stated he smokes whenever he wants. He verified when he goes outside, he turns off the oxygen and leaves his oxygen tank by the facility door away from the smoking area. When asked if staff takes his lighter, he stated, "No, they are my personal property." When asked if he wears a smoking apron, Resident 16 stated, "No, do you see any burn holes in my clothes?" 4. Review of the medical record document titled Resident face sheet indicated Resident 81 was admitted to the facility in February of 2017 with diagnoses that included heart disease, shortness of breath and COPD. A facility provided list of smokers identified Resident 81 as a smoker. Review of Resident 81's medical record document titled Clinical Observations - Safe Smoking - Risk, dated 11/22/17, indicated Resident 81 had a BIMS of 11/15 indicating his memory was moderately impaired. The document further indicated Resident 81 agreed to the facility's smoking policy and included agreeing to	F 689	**Upon admit and quarterly, the Activity Director will complete a smoking evaluation and care plan for residents that smoke.** **The facility will provide a copy of the smoking policy and a lock safe lock box for independent smokers.** **The facility smoking policy was updated on 1/8/18 to reflect the new smoking guidelines for independent smokers.** **The Director of staff Development is in servicing the staff through 1/12/18 on the updated smoking policy.** **The Activity Director will report her weekly and monthly findings to the Director of nursing for follow up as needed.** **The Activity Director will report any non compliance issues to the quality assurance committee for**	

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F 689	Continued From page 5 smoking supervised during scheduled smoking times, required all smokers to wear an apron, and stipulated smoking materials were to be kept secured by staff. Review of Resident 81's medical record document titled Smoking Care Plan indicated Resident 81 is at risk related to decreased mobility and cognitive (pertaining to the mental processes of perception, memory, judgment and reasoning) impairment and requires supervision while smoking, sometimes non compliant with smoking rules and schedule, and preferred to have his cigarettes in his possession. The goal was identified as "Resident will participate with smoking schedule" with interventions that included continue to educate and explain risks, educate resident to follow smoking time or schedules, keep lighters in secured area, encourage to use a smoking apron, monitor resident does not keep their lighter in their possession, provide supervision while smoking On 12/22/17 at 11:15 a.m., during a concurrent observation and interview, Resident 81 stated he has his own cigarettes and lighter and showed them to the Department. He additionally stated he smokes "whenever I want to." When asked if he wears a smoking apron, Resident 81 stated, "No, I am not a damn baby." During an interview on 12/21/17 at 4:11 p.m., Certified Nursing Assistant (CNA) 1 stated residents that are "alert" can keep cigarettes and lighters at the bedside. Smokers listed as "supervised" on the list cannot keep cigarettes and lighters at the bedside. Smokers listed as "independent" can keep their cigarettes and lighters in their room.	F 689	**recommendations as needed.**	

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F 689	Continued From page 6 On 12/21/17 at 3:57 p.m., during an interview with CNA 2, CNA 2 stated, "Cigarettes and lighters are locked up at the nurses station, they can never have lighters at the bedside." During an interview on 12/21/17 at 4:30 p.m., Licensed Nurse (LN) 4 stated unsupervised smokers lighters must be kept at nurse's station or with activities department staff. During an interview on 12/22/17 at 11:20 a.m. the Activities Director (AD) stated no residents have lighters kept with them. The AD further stated they are kept at the nurses station or in the activities office. The AD stated she was surprised these residents have their own lighters in their rooms and confirmed they should not have them. The AD stated she does not know how they got them. Review of the facility policy titled Residents Smoking Policy - (Tobacco, Electronic and Vapor Cigarettes, Marijuana), revised July 2017, stipulated "...The facility may revoke resident smoking privileges should the resident refuse to comply with the facility's safety policy regarding smoking, to include smoking without supervision and keeping smoking paraphernalia within the resident's possession...Smoking paraphernalia will be kept for safety at a designated safe storage area other than in the resident's room or resident possession... staff monitoring the Resident Smoking Program may check periodically to determine if residents have any smoking articles in violation of the smoking policies."	F 689		
F 726	Competent Nursing Staff	F 726		

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F 726 SS=F	Continued From page 7 CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure each Licensed Nurse (LN) had the appropriate skills and competencies to care for residents based on their identified needs, and failed to assess and	F 726	**F-726** **The licensed nurses' competency evaluation form was revised on 1/8/2018.** **Upon hire, annually and on as needed basis, the Director of Nursing (DON) or designee will perform the employees competency evaluations.** **The competency evaluations will be performed via a work shop where the licensed nurse will learn and perform a return demonstrate on their skills/understanding. Skill checks will also be performed at bedside if necessary by the DON or her designee. The Licensed Nurse will have the opportunity to demonstrate their competeney level.**	

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F 726	Continued From page 8 document those skills for each LN. This failure potentially placed residents' safety at risk, when LNs' skills were not demonstrated. Findings: 1. On 12/19/17, at 3:07 p.m., Resident 5 was observed to have left and right nephrostomy tubes (A tube inserted directly into the kidney through the skin to allow permanent or temporary drainage of urine). The urine collection bags were resting at hip level on the mattress. A review of the Nurses Notes, dated 11/25/17 and 11/29/17, indicated Resident 5 went to the hospital, on 11/25/17, for a blocked nephrostomy tube, and returned to the facility, on 11/29/17. The medical record indicated a physicians order, dated 11/29/17, to flush each nephrostomy tube daily with 10 ml (milliliter, a unit of measurement) of saline, and dressing change as needed. During an interview with Licensed Nurse (LN 1), on 12/22/17, at 1:30 p.m., she stated herself and another Licensed Nurse (LN 2) were the only ones who flushed the tubes, and dressing changes were performed twice weekly by any LN. When asked how the LNs were trained to perform site care and dressing changes, LN 1 stated she taught and observed an LN as they performed a site dressing change before allowing the nurse to perform the skill independently. LN 1 was not able to produce documented evidence of competency validation for nephrostomy tube flushing or site care and dressing change. She stated competencies were validated by a nurse's licensure. LN 1 stated nephrostomy tubes were not common, and estimated the facility had two to	F 726	**The facility Nurse Practitioner completed an in-service for licensed on caring for patients with nephrostomy tubes on 1/9/18.** **The DON or her designee will complete a return demonstration for licensed nurses on flushing/emptying/caring for nephrostomy tubes by 1/12/18.** **Each quarter competency evaluation will be scheduled. The LN will have an opportunity to perform a return demonstration of skills learned.** **The DON will review the licensed nurses' competency forms after completion.** **Recommendations will be implemented as needed.**	

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F 726	Continued From page 9 three residents with nephrostomy tubes per year. During an interview with the Director of Staff Development (DSD), on 12/22/17, at 2:15 p.m., she stated, the Director of Nursing (DON), and LN 1 gave an inservice on nephrostomy site care, on 10/19/17, where 20 LNs attended. When asked how the attendees were evaluated on their knowledge of the information received, the DSD stated, by having a group question and answer period. She confirmed individual attendee knowledge was not verified. 2. During an interview with the DON, on 12/22/17, at 3:15 p.m., she stated staff competencies are evaluated by skills check list. She stated, "Competencies are done for new employees and annually. I sit down with the staff to go over the check list and they sign it after we go over everything." The DON did not provide a competency check list that verified employees' demonstration of skills listed on skills form. During an interview with the DSD, on 12/22/17, at 2:15 p.m., she stated she validated employee competencies during Skills Days (a day dedicated to reviewing and evaluating job skills). She was unable to provide documentation on the details of the content covered during the Skills Days, evidence of employee demonstration of the skills being evaluated, or dates on which the Skills Days were held. During a concurrent review of four employee (LN 1, LN 2, LN 3, DON) records, each record contained a form titled "Licensed Nurse Annual Proficiency Test." The DSD confirmed the topics on the form were similar to the topics covered during new employee orientation. Each form	F 726	**The Director of Nursing will report any non compliance issues to the quality assurance committee for recommendations as needed.**	

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F 726	Continued From page 10 indicated the employee's initials next to each item, and a signature at the end of the form by the DON or the DSD. The form also indicated the statement "I acknowledge that I have had the above items reviewed/explained to me." During an interview with LN 3, on 12/22/17, at 3:30 p.m., he verified the initials next to each item were his. He stated some items were reviewed with the DON, but other items he self-evaluated himself as competent based on his familiarity with the item.	F 726		