California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA020000130	A. BUILDING: _____ B. WING _____	12/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE POST-ACUTE REHAB	336 DIABLO ROAD DANVILLE, CA 94526

(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) COMPLETE DATE
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during a staffing audit visit for 24 randomly selected days from 10/01/2019 to 12/31/2019. Representing the Department: W.C., Associate Governmental Program Analyst. Welfare and Institutions (W&I) Code section 14126.022 sets forth the Department's authority to conduct audits of direct caregiver nursing services provided to residents of skilled nursing facilities, and to establish procedures for conducting such audits through All Facility Letters (AFLs). <http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14126.022.&lawCode=WIC> AFL 19-16, setting forth the audit process and guidelines for facilities is available through the following link: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-19-16.pdf> Health and Safety Code (HSC) 1337-1338.5, sets forth the requirements for Certified Nurse Assistants is available through the following link: <https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?division=2.&chapter=2.&lawCode=HSC&article=9> W&I section 14126.022 requires the Department to assess an administrative penalty to a SNF if the Department determines that the SNF fails to meet the DHPPD requirements pursuant to HSC sections 1276.5 or 1276.65. The Department shall assess an Administrative penalty to any facility that fails to meet the applicable standard	A 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. This plan of correction is prepared and/or executed solely because the provisions of Federal and State Law require it. This Plan of Correction is submitted as the facility's credible allegation of compliance. A 205 HSC 1276.65 SAS- 2.4 Standard HSC 1276.65(c)(1)(C)SAS – 2.4 Standard The facility maintains that there are 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. The facility provides services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.	

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A 000	Continued From page 1 for staffing requirements on any given day. The applicable standard is 3.5 DHPPD and 2.4 DHPPD (CNA), unless an approved Workforce Shortage or Patient Needs Waiver is granted. Based on record review and interview, the above nursing facility was found in compliance with HSC 1276.65(c)(1)(B), the requirement for 3.5 Direct Care Service Hours Per Patient day. Final Audit Result: Total Distinct Non-Compliant Day(s) = 03	A 000	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: There were no residents affected by the practice. There was only a potential for residents to be affected. The Director of Nursing Services will meet with the Administrator to review the facility policies and procedures. Specifically, a review of the admission policy and care needs of the residents will be reviewed to ensure that the facility has sufficient nursing staff to provide the nursing and related services to ensure that the residents attain or maintain their highest practicable physical, mental and psychosocial status as determined by their assessments and individual plans of care.. The Administrator will ensure that the facility policy and practices are consistent with the requirements stated in the regulations. How the facility will identify other residents having the potential to be affected by the same deficient practice: There were no residents affected by the practice. There was only a potential for residents to be affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:	
A 205	HSC 1276.65(c)(1)(C) SAS - 2.4 Standard (C) Skilled nursing facilities shall have a minimum of 2.4 hours per patient day for certified nurse assistants in order to meet the requirements in subparagraph (B). This Statute is not met as evidenced by: Facility failed to meet 2.4 direct care service hours per patient day (DHPPD), performed by certified nurse assistants, pursuant to HSC 1276.65(c)(1)(C) for 3 out of 24 days. The statute was not met as evidenced by the following findings: The Director of Staff Development (DSD) failed to delineate time spent providing nursing services to skilled nursing care patients beyond the hours required to carry out the duties of the DSD position per AFL 19-16, section II, F.1.i. Employee(s) who fail to delineate time spent	A 205		

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A 205	Continued From page 2 providing nursing services to skilled nursing care patients, as defined in HSC section 1276.65 and CCR Title 22, section 72309, section 72311 and section 72315, while assigned to perform other duties other than direct care per AFL 19-16, section II, D.6. Employee(s) failed to document: actual shift and meal break start and end times, along with their nursing services assignment, discipline, printed name and signature when providing nursing services to skilled nursing patients (such as salaried staff). Time spent providing nursing services could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employee(s) per AFL 19-16, section II, F.1. Documents/records, other than payroll records, were incomplete, illegible, or inaccurate [AFL 19-16, section II, B.1]. Time spent providing direct care could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employees. Facility failed to maintain current, complete and accurate personnel and payroll records for all employees in accordance with CCR Title 22, section 72533 and per AFL 19-16, section II, A. Time spent providing direct care could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employees. Time spent providing nursing services could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employees per AFL 19-16, section II, A. Facility failed to replace staff that did not work as	A 205	The Director of Nursing Services, Nursing Supervisor, Administrator, and/or designee will meet regularly to review the current census levels, upcoming admissions and discharges and the staffing ladder. The staffing ladder is a tool used to calculate the daily PPD based upon the census and daily staffing requirements. How the facility plans to monitor its performance to make sure that solutions are sustain. This plan will be implemented, and the corrective action evaluated for its effectiveness. This plan of correction is integrated into the Quality Assurance Performance Improvement (QAPI) program. The Clinical Care Subcommittee, of the Quality Assurance Performance Improvement Committee, chaired by the Director of Nursing Services, shall review staffing levels to ensure there is sufficient nursing staff to provide nursing and related services to the residents on a quarterly basis to ensure compliance. Responsible: Director of Nursing Services, Nursing Supervisor/designee. Date of Completion: April 01, 2022	

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A 205	Continued From page 3 scheduled, and/or did not schedule to meet the minimum staffing requirements. The total number of actual direct care nursing hours performed by direct caregivers per patient day divided by the average census during the patient day failed to meet DHPPD Staffing Standard(s) per AFL 19-16. Review of the documentation provided for audited day(s) resulted in the following Non-Compliant DHPPD result: DATE 2.4 CNA DHPPD 10/31/2019 2.22 12/24/2019 2.39 12/31/2019 2.28	A 205		

Danville
POST-ACUTE REHAB
AT HR SKILLED NURSING

INSERVICE SIGN-IN SHEET

Topic: Staffing PPD

Instructor: Taylor Ellis Date: 03/31/2022 Hours: _____

By signing your name below, you are agreeing that you have been thoroughly trained on the topic listed. You are also verifying your understanding and acknowledgement of this training.

NAME	DEPT	SIGNATURE
Katrina Manalayaay	LVN	
Jessie Hecht	RN-DON	

Danville
POST-ACUTE REHAB
24 HR SKILLED NURSING
PROVIDING COMPASSIONATE CARE & INNOVATIVE REHAB SERVICES

STAFFING INFORMATION FOR March 31, 2022

Resident Census 46

HPPD 3.7

CNAPPD 2.5

Shift: 7am-3pm

	Number of Staff	Total Hours
RN	1	8
LVN	2	16
CNA	7	52.5

Shift: 3pm-11pm

	Number of Staff	Total Hours
RN	1	8
LVN	2	8
CNA	5.5	41.25

Shift: 11pm-7am

	Number of Staff	Total Hours
RN	1	8
LVN	1	8
CNA	3	22.5

DON _____ **DESIGNEE** _____ **ADMIN** _____

State of California—Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, MD, DRPH
Director and State Public Health Officer

GAVIN NEWSOM
Governor

COMPONENTS OF AN ACCEPTABLE PLAN OF CORRECTION

March 21, 2022 **CERTIFIED MAIL**

Taylor Ellis-Sherinian
Danville Post-Acute Rehab
336 Diablo Road
Danville, CA 94526-3417

Dear Taylor Ellis-Sherinian:

Facility ID: 140000130

Enclosed please find a Statement of Deficiencies and Plan of Correction form. Staff of the Licensing and Certification Program identified the deficient practice during a visit to your facility. Please prepare a Plan of Correction, sign and date the document, and, within 10 days, return the original to:

California Department of Public Health
Licensing and Certification, Staffing Audit Section
ATTN: POC Coordinator
1615 Capitol Avenue, Room 73.630
PO BOX 997377, MS 3203
Sacramento CA 95899-7377

The Plan of Correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into the quality assurance system. The Plan of Correction for each deficiency must contain the following:

a) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.

b) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel) as well as how the facility plans to monitor its performance to ensure corrections are achieved and sustained.

c) Dates when corrective action will be completed. The corrective action completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance.

The previous list includes those components that must be included in every Plan of Correction. Please retain a copy of the completed Statement of Deficiencies and Plan of Correction form for your file.

A rebuttal of the deficiency is not a Plan of Correction. California Health and Safety Code, Section 1280, requires a Plan of Correction for all deficiencies. By providing a Plan of Correction, a licensee or designee does not necessarily admit guilt of any violation nor does this interfere with the right to contest or appeal any alleged violation.

If your Plan of Correction is unacceptable to the Department, you will be notified in writing. You are ultimately accountable for compliance and responsibility is not alleviated when notification of the acceptability of the Plan of Correction is not timely. Your Plan of Correction will serve as the facility's allegation of compliance. The original signed Plan of Correction must be maintained at the facility for a minimum of three years.

Should you have questions, please contact me via LNCStaffingAudits@cdph.ca.gov.

Respectfully,

Debra Gonzales Digitally signed by Debra Gonzales
Date: 2022.03.21 11:49:32 -07'00'

Debra Gonzales
Section Chief, Staffing Audit Section

Enclosures: Statement of Deficiencies and Plan of Correction Form
Final Facility Audit Dates and NHPPD Summary Report
Final Facility NHPPD Non-Compliant Days Summary Report
Notice of Intent

cc: Danville Long-Term Care, Inc.
336 Diablo Road
Danville, CA 94526

Kara Read-Spangler, Office of Legal Services
California Department of Public Health
1415 L Street, Suite 500
Sacramento, CA 95814-3964

Signature of Facility Representative
Receiving Letter

03/31/2022

Date Letter Returned With
Plan of Correction

Taylor Ellis

Complete, Printed Name of Facility
Representative Receiving Letter

Note: Sign, date, and return this letter with the Plan of Correction

State of California—Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, MD, DRPH
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Notice of Intent to Issue an Administrative Penalty And Notice to Correct a Violation

The Director of the California Department of Public Health, through the Deputy Director of the Center for Health Care Quality, Licensing and Certification Program, has reasonable cause to determine that an alleged violation of the California Health and Safety Code §1276.5 or 1276.65 has occurred, which will result in the issuance of an Administrative Penalty.

SECTIONS VIOLATED

- HSC §1276.5 3.2 DHPPD
  or
- HSC §1276.65 3.5 DHPPD and/or 2.4 CNA DHPPD

Action to correct this violation(s) must commence immediately and be addressed in the facility Plan of Correction (POC).

This notice issued to **Danville Post-Acute Rehab** on **03/21/2022**.

By: Debra Gonzales
Section Chief, Staffing Audits Section

Debra Gonzales Digitally signed by Debra Gonzales Date: 2022.03.21 11:49:10 -07'00'
Signature

I acknowledge receipt of this Notice 03/31/2022.
Month/Day/Year

By: Taylor Ellis
Designee name

Signature

Staffing Audits Section, MS 3203 • P.O. Box 997377 • Sacramento, CA 95899-7377
(916) 552-8900 • (916) 636-6051 FAX
Internet Address: www.cdph.ca.gov