- POC Accepted 7/14/15 with Rctn. [redacted]

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

PRINTED: 06/30/2015
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
	056212	A. BUILDING _____ B. WING _____	C 06/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW GLEN CENTER	1267 MERIDIAN AVENUE SAN JOSE, CA 95125

(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 regarding investigation of two entity reported incidents and a complaint conducted on 6/24/15. For Entity Reported Incident CA00445319 regarding Resident Rights, no Federal or State deficiencies were identified. For Entity Reported Incident CA00447228 regarding Resident Abuse, no Federal or State deficiencies were identified. For Complaint CA00447201 regarding Nursing Services, a Federal deficiency was identified (see F425). Inspection was limited to the specific complaint and entity reported incidents investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 35386, Health Facilities Evaluator Nurse and 32999, Health Facilities Evaluator Nurse.	F 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH JUL 10 2015 L & C DIVISION SAN JOSE	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	See next page	

LABO[redacted] R REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 7/7/15

Any [illegible] 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056212	A. BUILDING _____ B. WING _____	C 06/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW GLEN CENTER	1267 MERIDIAN AVENUE SAN JOSE, CA 95125

(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 425	Continued From page 1 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the pharmaceutical services for one of five residents (1) and three non-sampled residents (6, 7 and 8). For Resident 1, insulin was administered accidentally to the resident who did not require the insulin. For Residents 6 and 7, their insulin vials were not discarded after expiration and Resident 8's insulin vial was undated. These failures could lead to errors in treatment and the expired medications have the potential to lose their therapeutic effect and prevent residents from receiving the full benefits of the medications. Findings: 1. Review of Resident 1's closed clinical record (a record for a resident no longer residing in the facility) indicated Resident 1 was admitted to the facility on 6/12/15 and was not diabetic. Review of Resident 1's Progress Notes "Medication Error" dated 6/14/15, indicated licensed vocational nurse A (LVN A) administered	F 425	F 425: Corrective Action: 1. On 6/14/15 Resident 1 was accidentally given insulin by LVN A. LVN A realized her mistake and immediately began monitoring Resident 1 for negative reactions to the mistakenly given insulin. There were no negatively reactions. The RP and PCP were notified. Resident 1 discharged on 6/15/15. 2. On 6/24/15 the expired insulin for Residents 6 & 7 and the undated insulin for Resident 8 were discarded the same day they were discovered. The PCPs were notified and a new insulin was given each of these Residents from the E-kit per PCP order. Other Residents: 1. By 6/25/15 Nursing Station Managers checked each resident receiving insulin to ensure they received the correct insulin. 2. By 6/25/15 Nursing Station Managers checked each insulin bottle in the facility to ensure that none were expired or undated. Systemic Changes: 1. On 6/16/15 the DON counseled and wrote up LVN A for this mistake. All nurses will be in-serviced by 7/10/15 to ensure they administer the right med to the correct resident. 2. By 7/10/15 all nurses will be in-serviced by the DSD to ensure we don't keep expired or undated insulin medications. Monitoring: The Nursing Station Managers will manage these processes and the DON will bring these issues to QAA for review and follow up as needed.	7/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056212	A. BUILDING _____ B. WING _____	C 06/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW GLEN CENTER	1267 MERIDIAN AVENUE SAN JOSE, CA 95125

(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 425	Continued From page 2 insulin to Resident 1 which was intended for another resident. Review of LVN A's Orientation Training and Competency Checklist dated 7/7/14, indicated residents were identified prior to preparing medications and five rights (right resident, right medication, right dose, right time and right routes) should be observed when administrating medications. During an interview with LVN A on 6/24/15 at 3:15 p.m., LVN A stated she administered the insulin to Resident 1 accidentally. LVN A stated she did not identify Resident 1 before administering the insulin. During an interview with the director of nursing (DON) on 6/24/15 at 3:45 p.m., she stated the licensed nurses should identify residents prior to administering medications. Review of the facility's policy "Medication Administration" dated 5/5/11 indicated the licensed nurse shall check the resident's identity prior to administration of medications. 2. During an observation on 6/24/15 at 4:20 p.m., LVN B prepared Novolog (a type of insulin) for a non-sampled resident (Resident 6). The insulin vial (a small bottle) was dated 5/25/15. During a concurrent interview, LVN B stated she did not check the expiration date of the insulin before she prepared it. LVN B stated the insulin was not expired because she followed the manufacturer's expiration date which was printed as 01/2018 on the insulin vial. On 6/24/15 at 4:45 p.m. with LVN A, a vial of	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056212	A. BUILDING _____ B. WING _____	C 06/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW GLEN CENTER	**1267 MERIDIAN AVENUE SAN JOSE, CA 95125**

(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 425	Continued From page 3 Novolog for a non-sampled resident (Resident 7) dated 5/17/15 and a vial of Humulin R (a type of insulin) undated for a non-sampled resident (Resident 8) were found in a medication cart. LVN B stated two vials of Novolog for Residents 6 and 7 were expired and should be discarded. During an interview with the director of nursing (DON) on 6/24/15 at 5 p.m., she stated Novolog insulin expired 28 days after it was opened and there should be a date on the insulin vial as to when it was opened Review of the facility's policy "Medication Storage" dated 10/07 indicated to date insulin vials when first opened. Review of the facility's policy "Medications with Special Expiration Date Requirements" dated 2007 indicated the Novolog vial expires 28 days after it is opened.	F 425		