

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

PRINTED: 10/01/2014
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
FORM APPROVED OF PUBLIC HEALTHOMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055240	(X2) MULTIPLE CONSTRUCTION A. BUILDING OCT 14 2014 B. WING L & C DIVISION SAN JOSE		(X3) DATE SURVEY COMPLETED C 09/26/2014
NAME OF PROVIDER OR SUPPLIER WATSONVILLE NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 535 AUTO CENTER DRIVE WATSONVILLE, CA 95076		
(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 a complaint investigation conducted on 9/18/14-9/24/14. For Complaint CA00412290 regarding Resident/Patient/Client Assessment, Federal deficiencies were identified (see F281, F428 and F505). Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 34234, Health Facilities Evaluator Nurse; 22899, Health Facilities Evaluator Nurse 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow a physician's order to give medications for one of three residents (1). Coumadin (a blood thinner) 1.25 milligrams (mg) by mouth daily was not given to Resident 1 on 6/27/14 to 6/30/14. This failure had the potential to affect the effectivity of the medication. Findings: Review of Resident 1's physician order dated	F 000	Watsonville Nursing Center submits this plan of correction as part of the requirements under State and Federal Law. The Plan of Correction is submitted in accordance with specific requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employees, agents, officers, directors or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third for evaluation and appropriate treatment modalities. F281- Services provided meet professional standards Resident #1 was discharged from the facility on 7/15/14. All residents have the potential to be affected by this deficient practice. An audit will be completed by the Director of Nursing (DON) and/or designee of all residents on Coumadin within the last 30 days to ensure all physician orders regarding the		
F 281 SS=D		F 281		7/15/14 10/27/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with "may be excused" 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.

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

PRINTED: 10/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2014
NAME OF PROVIDER OR SUPPLIER WATSONVILLE NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 535 AUTO CENTER DRIVE WATSONVILLE, CA 95076		
(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 281	<p>Continued From page 1</p> <p>6/20/14 indicated to hold Coumadin and then to restart it at 1.25 mg by mouth daily when the International Normalized Ratio (INR, a system for reporting the results of blood clotting tests) drops below 3.</p> <p>Review of Resident 1's laboratory results dated 6/27/14 revealed the INR was 2.08 and on 6/30/14 the INR was 1.41.</p> <p>Review of Resident 1's Medication Administration Record (MAR) for the month of June 2014 revealed an entry of Coumadin 1.25 mg by mouth daily. There were no signatures indicating the medication was given on 6/27/14 to 6/30/14 (when INR was below 3).</p> <p>During interview on 9/24/14 at 2:42 p.m., licensed nurse (LN) 2, who was the nurse on the evening of 6/27/14, stated she did not give the Coumadin but should have given the Coumadin as ordered based on the INR which was 2.08.</p> <p>During an interview on 9/24/14 at 3:10 p.m., licensed nurse (LN) 3 who was the nurse on the evening of 6/30/14, stated she did not give the Coumadin but should have given the Coumadin as ordered based on the INR which was 1.41.</p> <p>Review of the California Business and Professions Code, Section 2725(b)(2) indicated nurses are to administer medications necessary to implement a treatment ordered by and within the scope of licensure of a physician.</p>	F 281	<p>International Normalized Ratio (INR) and the corresponding medication orders have been carried out.</p> <p>The DON and/or designee gave in-services to the Licensed Nurses indicating nurses are to administer medications necessary to implement a treatment ordered by and within the scope of licensure of a physician. This in-service was completed on 9/30/14.</p> <p>A weekly audit will be completed by the DON and/or designee of all residents on Coumadin to ensure all physician orders regarding the INR and the corresponding medication orders have been carried out.</p> <p>The DON will provide the CQI committee with a summary trend analysis of the audit findings. This CQI committee will review for further evaluation and recommendation.</p>		9/30/14
F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be</p>	F 428	<p>F428 – Drug regimen review, Report irregular</p> <p>Resident #1 was discharged from the facility on 7/15/14.</p>		7/15/14

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

PRINTED: 10/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2014
NAME OF PROVIDER OR SUPPLIER WATSONVILLE NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 535 AUTO CENTER DRIVE WATSONVILLE, CA 95076		
(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 428	<p>Continued From page 2</p> <p>reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct a medication regimen review (MRR) for one of three residents (1). This failure resulted in laboratory tests not being performed as needed.</p> <p>Findings:</p> <p>Review of Resident 1's physician order dated 6/20/14 indicated an order for Coumadin (a blood thinner medication) and International Normalized Ratio (INR, a system for reporting the results of blood clotting test) laboratory test to be done on 6/27/14 and 6/30/14.</p> <p>Review of Resident 1's laboratory results dated 6/27/14 revealed the INR was 2.08 and on 6/30/14 the INR was 1.41.</p> <p>During a telephone interview on 9/23/14 at 10:30 a.m., consultant pharmacist (CP) 1 stated the only MRR she did for Resident 1 was on 7/13/14 and she did not have any recommendations.</p> <p>Review of Resident 1's MRR dated 7/15/14 by CP 2 indicated there were no recommendations</p>	F 428	<p>All residents have the potential to be affected by this deficient practice.</p> <p>The DON and/or designee has in-serviced the licensed nursing staff on sending and following up with the physicians on the Medication Regimen Reviews, (MRR) and pharmacists recommendations. This in-service was completed on 9/30/14.</p> <p>The Pharmacy consultant will review all residents medication regimen monthly and as needed.</p> <p>The Nursing Supervisor and/or designee will conduct on audit patients on Coumadin within 72hrs. of a MRR or pharmacist recommendation has been followed up with the physician in a timely manner. The audit findings will be given to the DON for further review and analysis.</p> <p>The DON will provide the CQI committee with a summary trend analysis of the audit findings. This CQI committee will review for further evaluation and recommendation.</p>	9/30/14	

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

PRINTED: 10/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2014
NAME OF PROVIDER OR SUPPLIER WATSONVILLE NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 535 AUTO CENTER DRIVE WATSONVILLE, CA 95076		
(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 428	Continued From page 3 regarding Resident 1's laboratory results and Coumadin medication.	F 428			
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the attending physician (MD) of the laboratory results for one of three residents (1). Protrombin Time (PT, blood clotting time) and International Normalized Ratio (INR, a system for reporting the results of blood clotting test) results were not relayed to the MD. This failure may result in an inappropriate action for resident care. Findings: Review of Resident 1's physician's orders dated 6/20/14 indicated an order of PT/INR blood tests be done on 6/30/14. Review of Resident 1's laboratory results dated 6/30/14 indicated PT/INR were drawn with the following results: PT was 15.2 and INR was 1.41. During telephone interview on 9/19/14 at 9:15 a.m., MD stated she was not made aware by the facility staff of the PT/INR lab results done on 6/30/14 for Resident 1 and she did not have any record of the lab results. During interview on 9/24/14 at 2:15 p.m., licensed nurse 1 (LN) stated he faxed the lab results to	F 505	F505- Promptly Notify Physician of Lab Results Resident #1 was discharged from the facility on 7/15/14. Lab results for Resident #1 were obtained by the DON on 6/30/14. These results have been re-faxed to the attending physician on 7/14/14 and filed in the clinical record. All residents requiring labs have the potential to be affected by this deficient practice. The DON and/or designee gave in- services to the Licensed Nurses on physician notification of laboratory results with PT/INR blood tests. This in-service was completed on 9/30/14. Medical Records and/or designee will audit laboratory results with PT/INR blood tests on a daily basis for physician notification. Medical Records will notify DON of negative audit findings that day. The DON will follow up with the licensed staff to ensure that timely physician notification has occurred and is documented.	7/15/14 6/30/14 7/14/14 9/30/14	

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

PRINTED: 10/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2014
NAME OF PROVIDER OR SUPPLIER WATSONVILLE NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 535 AUTO CENTER DRIVE WATSONVILLE, CA 95076		
(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 505	Continued From page 4 MD on 6/30/14 but stated he did not call MD about the results.	F 505	Medical Records will provide the CQI committee with a summary trend analysis of the audit findings. This CQI committee will review for further evaluation and recommendation.		

CALIFORNIA DEPARTMENT
OF PUBLIC HEALTH

OCT 14 2014

L & C DIVISION
SAN JOSE