PRINTED: 07/06/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056430	A. BUILDING _____ B. WING _____	C 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHGATE CARE CENTER	40 PROFESSIONAL CENTER PARKWAY SAN RAFAEL, CA 94903

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Complaint Investigation: CA307868. Representing the California Department of Public Health: Health Facility Evaluator Nurse 28012. Inspection was limited to the complaint investigation and does not represent the findings of a comlete inspection of the facility. Two deficiency was written as a result of Entitiy Reported Incident CA00307868.	F 000	Preparation and/or execution of this plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the Health and Safety Code Section 1280 and 42 CFR 405 .1 Section 7. CP Administrator's Initials	7/13/12
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	This plan of correction will serve as the facility's Credible Allegation of Compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: C. Prunesberger | TITLE: Administrator | (X5) DATE: 7/17/12

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...lowing 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 ...ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...ogram participation.

7/17/12 @ 2:40 pm SPOKE to Joy Murray

P.O. accepted by Jacqueline HFEM

RECEIVED
JUL 17 2012
By _____

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and chart review, the facility failed to develop a comprehensive plan of care for Resident 1, who demonstrated behaviors of yelling at staff during assessments/examination and making delusional statements refusing care and talking to self, when the care plan did not include interventions with instructions to direct care CNA staff as to how to approach the resident when providing care, resulting in the potential for increased delusional behaviors and emotional outbursts or distress for the resident. This failure had the potential to cause an increase in Resident 1's behaviors of yelling and striking out at staff and making delusional statements. Findings: Medical record review on 4/23/12, indicated that Resident 1's admission diagnosis included disease processes that include symptoms of delusional behaviors and emotional outbursts. Resident 1's medication included: Seroquel and Abilify both medications are used to treat the symptoms of illnesses that cause disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions and Depakote, used to treat mania (episodes of frenzied, abnormally excited mood). Resident 1 was also, wheel chair bound and in need of extensive physical assistance for activities of daily living eating and locomotion in her wheelchair. During an interview on 4/23/12 at 9:40 a.m., Resident 1 was able to recall the day and month. When asked about an alleged incident, Resident	F 279	A cognitive and behavioral, comprehensive care plan was developed that included interventions with instructions to direct care staff as how to approach resident when care is provided and the resident is having emotional outbursts or demonstrating delusional behavior. Staff were inserviced by the DNS & DSD on reporting all allegations of inappropriate behavior or abuse from the resident and specific care plan interventions to take when resident has emotional outbursts and delusional behavior, including approach resident calmly and explain procedures before initiating care; if resident is resistive to care, leave and approach later when calmer, offer alternatives, document behaviors, remove from over-stimulating environment, use consistent caregivers and correct resident when using inappropriate language or racial epithets when directed to other residents. Two Certified Nursing Assistants (CNA's) will provide care to resident at all times. The Director of Staff Development (DSD) will monitor compliance daily.	7/13/12

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F 279	Continued From page 2 1 stated that she was frighten by Staff A who was in her room on the telephone and at the same time was grabbing at a long thing inside his pants and making movements with his hips. Resident 1 denied harm or feelings of fear from other staff or visitors at the facility. During an interview on 5/15/12 at 9: 35 a.m., when asked about the incident, Staff A stated that it never happen and he did not know what Resident 1 was talking about. He stated Resident 1 always made up things or said things that were not true. During an interview on 5/15/12 at 2:20 p.m., Staff B stated that from what she has observed and heard (resisting care and making delusional statements) it was difficult to provide care to Resident 1 and that she had suggested to nursing administration and the owner of the facility that CNAs go into Resident 1's room two at a time to provide care to the resident. Record review on 5/15/12 reflected the following: Resident 1's "Care Area Assessment Review Report" dated 9/25/11, section cognitive loss/dementia summary notes reflected Resident 1 has periods of confusion. The care plan decision reflected was not to address the behavior in the plan of care. Resident 1's "Minimum Data Set" signed 1/5/12, in the category of behavior reflected verbal symptoms directed towards other (e.g., threatening, screaming and cursing at others). The "Medication Administration Record" for	F 279	Negative findings will be reported to the DNS for immediate follow-up. On-going concerns regarding compliance will be presented at the facility's Quality Assurance (QA) committee for review and follow up. All residents have the potential to be affected by the deficient practice as cited in, "The Statement of Deficiencies (2567). The Director of Nursing Services (DNS) is responsible for on-going compliance.	7/13/12

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F 279	Continued From page 3 4/1/2012 - 4/30/12 reflected that Resident 1 had: 1. One-hundred thirty-one episodes of yelling at staff during assessments/examination. 2. One-hundred fifty-three episodes of making delusional statements. 3. One-hundred twenty-five episodes of yelling out. 4. Sixty-two episodes of refusing peri care. 5. One-hundred thirty-seven episodes of talking to self. During interview on 5/15/12 at 3:30 p.m., when asked about Resident 1's cognitive and behavorial plan of care for the CNAs to follow while providing care, the Director of Nurses stated that there was not a plan of care for the CNAs to follow.	F 279		7/13/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and chart review, the facility failed to ensure accurate clinical records for	F 514	The DSD inserviced the CNA's regarding required documentation of resident's emotional outbursts and delusional behavior on the Activites of Daily Living (ADL) forms. The Medical Records Designee (MRD) will audit the ADL forms quarterly for compliance. Negative findings will be reported to the DNS for immediate follow-up. On-going concerns regarding compliance will be presented at the facility's QA committee for review and follow up.	

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F 514	Continued From page 4 Resident 1, when unlicensed staff repeatedly charted in the activities of daily living records that no negative behaviors occurred resulting in the potential for inaccurate assessments by licensed staff who utilized the information in the record. Findings: Medical record review on 4/23/12 indicated that Resident 1's admission diagnosis included disease processes that often result in a Resident suffering delusions or having outbursts of emotional distress. Resident 1's medications included: Seroquell and Abilify both medications are used to treat the symptoms of such disease processes such as illnesses that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions and Depakote, used to treat mania (episodes of frenzied, abnormally excited mood). Resident 1 was also wheel chair bound and in need of extensive physical assistance for activities of daily living eating and locomotion in her wheelchair. During an interview on 5/15/12 at 2:20 p.m., Staff B stated that from what she has observed and heard (resisting care and making delusional statements) it was difficult to provide care to Resident 1. During medical record review on 5/15/12, the "Medication Administration Record" for 4/1/2012 - 4/30/12 reflected that Resident 1 had: 1. One-hundred thirty-one episodes of yelling at staff during assessments/examination. 2. One-hundred fifty-three episodes of making delusional statements. 3. One-hundred twenty-five episodes of	F 514	All residents have the potential to be affected by the deficient practice as cited in, "The Statement of Deficiencies" (2567). The Director of Nursing Services (DNS) is responsible for on-going compliance.	7/13/12

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F 514	Continued From page 5 yelling out. 4. Sixty-two episodes of refusing peri care. 5. One-hundred thirty-seven episodes of talking to self. During chart review on 5/15/12, the Certified Nursing Assistance (CNA) charting for March 2012, April 2012, and up to May 14. 2012, reflected that Resident 1 did not exibit screaming, refusing personal care, or demonstrate threatening behaviors. During concurrent interview on 5/15/12, at 3:30 p.m., when asked about the CNA charting, the Director of Nursing stated that it appeared that some training was in order for the CNAs regarding charting behaviors.	F 514		7/13/12