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

PRINTED: 07/21/2016
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
	056410	A. BUILDING _____ B. WING _____	C 07/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITNEY OAKS CARE CENTER	3628 WALNUT AVENUE POC acceptable 8/17/16 CARMICHAEL, CA 95608 LS Pinkham HFES

(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 for the investigation of entity reported Incident #CA00473288. Representing the Department of Public Health: HFEN, 17069 The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility.	F 000	"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." Preparation and/or execution of this Plan of Correction do not constitute admission by the Provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it's required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 483."	8-1-16
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident A) was treated with dignity and respect when Certified Nursing Assistant (CNA) 1 took a pillow and placed it over Resident A's face twice. This had the potential for Resident A to feel minimized. Findings. Resident A's Admission Minimum Data Set (MDS - an assessment tool), dated 1/20/16, described Resident A as having short and long-term memory problems, usually able to make herself understood, usually able to understand others,	F 241	F-241 The resident was discharged home on 1/20/16 in stable condition. For current and future residents that have the potential to be affected by this deficient practice, the facility customer service representative and the Social Services Director interviewed 15 random residents regarding dignity/respect and no concerns were identified. The Director of Staff Development (DSD) in serviced the staff on 1/28/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE RN | (X6) DATE 8-1-16

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 241	Continued From page 1 and as having severely impaired cognitive skills for daily decision making. It also described Resident A as having inattention, disorganized thinking, altered level of consciousness, and psychomotor retardation (a slowing-down of thought and a reduction of physical movements). The MDS further described Resident A as needing extensive assistance with bed mobility, dressing, and personal hygiene, and as dependent upon staff for transferring. Resident A's clinical record indicated she had a diagnosis of cerebrovascular accident (CVA - also known as a stroke) with right sided weakness with dysphasia (difficulty in swallowing) and aphasia (difficulty in speaking). The facility's investigation report, dated 1/24/15 (sic), indicated on the day Resident A was to be discharged from the facility (1/20/16), the facility's customer service representative met with Resident A's family to discuss the stay at the facility. At that time, Resident A's daughter stated she had a concern regarding CNA 1. On 1/20/15 (sic) the Director of Nursing (DON) called Resident A's daughter to follow up with her concern. The daughter stated on 1/6/15 (sic), CNA 1 and CNA 2 were in the room giving care to Resident A. CNA 1 took a pillow and placed it over Resident A's face. Resident A took the pillow off and placed it over by her side. A few minutes later, CNA 1 took the pillow and placed it over Resident A's face again. The daughter stated CNA 1 then reached over Resident A and " pinned down her left arm, " which is Resident A's stronger arm, in an attempt to have Resident A use her right arm, the weaker arm, to remove the pillow. As the daughter observed this, she	F 241	&1/29/16, regarding dignity and respect for our residents. The Certified Nurse Assistant (C.N.A) that was involved with this incident was terminated on 1/24/16. Upon discharge, the facility customer care representative will visit with residents/family members to review their stay. Concerns will be forwarded to the Director of Nursing (DON) or designee for resolution. Weekly times four weeks, then monthly thereafter, the DSD will perform customer service interviews with random residents/family members. In services will be given on as needed basis to resolve any concerns. The facility DSD performs scheduled quarterly abuse in-services, annual respect in-services and on as needed basis. Resident council meetings are held monthly. The Activity Director (AD) will review resident rights during the meetings. Any concerns identified will be forwarded to the DON or designee for follow up. The DSD will report any non compliance issues to the quality assurance committee for recommendations as needed.	

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F 241	Continued From page 2 quickly stood up from where she was sitting and asked him not do anything like that again. CNA 2 then asked CNA 1 to leave the room. The facility's interview with CNA 2, dated 1/21/16, indicated CNA 2 asked CNA 1 to assist her in positioning Resident A. CNA 2 stated while they were giving care, CNA 1 was laughing and threw a pillow on Resident A's face. Resident A threw it off and CNA 1 threw it back on her again. CNA 2 stated she noticed Resident A's daughters face looked displeased. CNA 2 stated she informed Registered Nurse (RN) 1 of the incident so she could talk to CNA 1 about not playing like that with certain residents as CNA 2 could tell Resident A's daughter did not like it. CNA 2 went back into Resident A's room and apologized for CNA 1's actions. Resident A's daughter was thankful, but did not want CNA 1 caring for her mother anymore. CNA 2 stated the daughter did not like the way CNA 1 interacted with her mother and felt he "crossed a line." CNA 2 was interviewed via telephone on 2/16/16 at 12:45 p.m. She stated she was assigned to Resident A and it was time for her to be repositioned. CNA 2 stated she asked CNA 1 to help her. CNA 2 stated CNA 1 likes to "play a lot" and "kid around." CNA 2 stated after they finished repositioning Resident A, CNA 1 was at the end of the bed putting pillows under Resident A's legs and feet. CNA 2 stated CNA 1 tossed a pillow up to Resident A that landed on Resident A's face. Resident A took the pillow off her face and tossed it back to CNA 1. CNA 1 then proceeded to toss it back to Resident A and it landed near Resident A's head. CNA 2 stated Resident A's daughter was present in the room and she could tell the daughter was not happy by	F 241		

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F 241	Continued From page 3 the expression of her face. CNA 2 stated she took the linen to the dirty linen cart and informed RN 1 of the incident. CNA 2 stated she knew CNA 1 was playing around, but described Resident A as a serious person. CNA 2 was asked if CNA 1 had "joked around" with Resident A before this incident. CNA 2 stated not that she knew of. CNA 2 stated she went back into Resident A's room and apologized. Resident A's daughter was thankful, but didn't want CNA 1 caring for Resident A again. The facility's interview with RN 1, dated 1/21/16, indicated on the day of the allegation CNA 2 notified RN 1 regarding the incident between CNA 1 and Resident A. RN 1 stated she spoke with Resident A's daughter, who stated she did not like CNA 1's interaction with her mother. The daughter felt he had "crossed a line" in his method of encouraging Resident A to participate in her care. RN 1 stated it was reported to her that when CNA 1 and CNA 2 were repositioning Resident A, the pillow "flipped up onto resident's face and [CNA 1] laughed about it." RN 1 stated she was not told about any intentional placement of the pillow over Resident A's head or face. RN 1 stated her impression was that during care the pillow flipped up onto Resident A's face and the reason for removing CNA 1 from caring for Resident 1 was because he laughed about it. RN 1 did not get the impression anything abusive had happened or was being alleged. The facility's report, dated 1/24/15 (sic), indicated RN 1 spoke with CNA 1 about the concern and told him "not to act in this manner again." The facility's interview with CNA 1, dated 1/21/16, indicated CNA 1 was asked if he placed a pillow	F 241		

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F 241	Continued From page 4 over Resident A's head. He acknowledged he did " for less than two seconds in a joking playful manner. " CNA 1 stated the pillow was on Resident A's head and was not covering her face. CNA 1 also stated that he, CNA 2, and Resident A's daughter were all talking and laughing together. CNA 1 stated he only put the pillow on Resident A's head once. CNA 1 stated Resident A's daughter was "afraid" and that he apologized and told the daughter he did not mean anything by it and that he was trying to get Resident A to use her weak arm. CNA 1 stated he spoke to the daughter and told her he was joking around and trying to get the resident to use her hands to move the pillow herself to get her to use her arms. CNA 1 also stated he thought "he was being creative in encouraging the resident to utilize her limbs." During an interview with the Director of Nursing (DON), on 3/21/16 at 10:45 a.m., she stated putting a pillow on a resident's face was "not a way to play with residents." The DON stated CNA 1 was suspended on 1/20/16 and terminated due to his " not appropriate way " to interact with residents.	F 241		