PRINTED: 07/21/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/GLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE BURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ C 058410 B. WING 07/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE POC acceptable 8/17/16 3629 WALNUT AVENUE WHITNEY OAKS CARE CENTER Pukham CARMICHAEL, CA 95808 Y. PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (X\$) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR USC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DAT DEFICIENCY "This plan of correction is prepared as F 000 'INITIAL COMMENTS F 000 part of the quality assurance process for the provider. This plan of correction and The following reflects the findings of the California Department of Public Health during an any attached documents are prepared with abbreviated survey for the investigation of entity substantial reliance upon privileged peer reported Incident #CA00473288. review information and/or reports and as such are protected from discovery." Representing the Department of Public Health; HFEN, 17069 Preparation and/or execution of this Plan The inspection was limited to the specific entity. of Correction do not constitute admission reported incident investigated and does not by the Provider of the truth of the facts represent the findings of a full Inspection of the alleged or conclusions set forth on the facility. Statement of Deficiencies. This Plan of F 241 F 241 483.15(a) DIGNITY AND RESPECT OF Correction is prepared and/or executed SS=D INDIVIDUALITY solely because it's required by the provisions of Health and Safety Code The facility must promote care for residents in a Section 1280 and 42 C.F.R. 483." manner and in an environment that maintains or enhances each resident's dignity and respect in F-241 full recognition of his or her individuality. The resident was discharged home on This REQUIREMENT Is not met as evidenced 1/20/16 in stable condition. Based on Interview and record review, the facility falled to ensure 1 of 3 residents (Resident A) was For current and future residents that have treated with dignity and respect when Certified the potential to be affected by this Nursing Assistant (CNA) 1 took a pillow and deficient practice, the facility customer placed it over Resident A's face twice. This had service representative and the Social the potential for Resident A to feel minimized. Services Director interviewed 15 random residents regarding dignity/respect and no Findings. concerns were identified. Resident A's Admission Minimum Data Set (MDS - an assessment tool), dated 1/20/16, described Resident A as having short and long-term The Director of Staff Development memory problems, usually able to make herself (DSD) in serviced the staff on 1/28/16 understood, usually able to understand others,

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other pariety are 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 thase documents are made evailable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

RN

8-1-16

(XII) DATE

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

PRINTED: 07/21/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING			TATAL DICHIONIO GUNTAIDES				0440-056	
NAME OF PROVIDER OR SUPPLIER WHITNEY OAKS CARE CENTER CARMICHAEL, CA 95608 CACROS-REFERENCED D THE APPROPRIATE TAG COntinued From page 1 PROVIDER LA 15 CATON SHOULD ARRIVE TAG CROSS-REFERENCED D THE APPROPRIATE TAG CACROS-REFERENCED D THE APPROPRIATE CACOL PACH 15 CACH 15 CAC	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	STICKLE BUILDINGS.		(X3) DATE SURVEY COMPLETED		
WHITNEY OAKS CARE CENTER (X4) D SUMMARY STATEMENT OF DEFICIENCES (PREFIX TAG) (RACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) 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 assistence with bed mobility, dressing, and personal hyglene, and as dependent upon staff for transforring. Resident A's clinical record indicated she had a diagnosis of cerebrovascular socident (CVA - aiso 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 DSD performs scheduled quarterly abuse in-services, annual respect for moderation and provided with the facility DSD performs scheduled quarterly abuse in-services, annual respect for continued From page 1 ### A1/29/16, 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 oustomer carepresentative will visit with residents/family members to review the stay. Concerns will be forwarded to the Director of Nursing (DON) or designed for resolution.	056410			B. WING	I	C 07/20/2018		
CARMICHAEL, CA 95608 CARMICHAEL, CA 95608 CARMICHAEL, CA 95608 CACHOPATION CARMICHAEL, CA 9560	HAME OF F	PROVIDER OR SUPPLIER	1-1-1-1		TREET ADDRESS, CITY, STATE, ZIP CO			
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 psychometer 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 transforring. 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 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	WHITNE,	EY OAKS CARE CENT	ER					
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 transforring. Resident A's clinical record indicated she had a diagnosis of cerebrovascular socident (CVA - also known as a stroke) with right sided weakness with dysphasia (difficulty in swallowing) and aphasia (difficulty in swallowing). The facility's investigation report, dated 1/24/15 (slc), 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 discoust the stay at the facility. At that time, Resident A's daughter stated	PREFIX	RACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	D BE COMPLETIC	
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 end 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 ard "pinned fown her left arm, " which is Resident A use her right arm, the weaker arm, to remove the pillow. As the daughter observed this, she	F 241	and as having several for daily decision of Resident A as having his psychomotor retark thought and a reduction of the MDS further displayed extensive dressing, and persident A's clinical diagnosis of cerebic known as a stroke with dysphasia (difficulty). The facility's investigation of the facility's investigation of the facility's investigation of the facility investigation of the facility investigation of the facility investigation of the facility. At that times he had a concerning on 1/20/15 (sic) the called Resident A's family facility. At that times he had a concerning on 1/20/15 (sic) the called Resident A's concerning of the facility. The dau over Resident A's pillow off and place minutes later, CN/over Resident A's stated CNA 1 then in pinned down her A's stronger arm, A use her right arm	arely impaired cognitive skills naking. It also described ing inattention, disorganized vel of consciousness, and dation (a slowing-down of action of physical movements), escribed Resident A as assistance with bed mobility, onal hyglene, and as itaff for transferring. all record indicated she had a rovascular accident (CVA - als.) with right sided weakness floutly in swallowing) and in speaking). tigation report, dated 1/24/16 the day Resident A was to be ne facility (1/20/16), the facility's representative met with y to discuss the stay at the ne. Resident A's daughter state in regarding CNA 1. The Director of Nursing (DON) is daughter to follow up with he aghter stated on 1/6/15 (sic.), were in the room giving care to 1 took a pillow and placed it face. Resident A took the ed it over by her side. A few A 1 took the pillow and placed if face again. The daughter is reached over Resident A and face again. The daughter is reached over Resident In an attempt to have Resident In an attempt to have Resident In an attempt to have Resident In the weaker arm, to remove	d t	for our residents. The Certified Nurse Assistant that was involved with this in terminated on 1/24/16. Upon discharge, the facility or representative will visit with residents/family members to a stay. Concerns will be forwar Director of Nursing (DON) or for resolution. Weekly times four weeks, the thereafter, the DSD will perfeservice interviews with randoresidents/family members. In be given on as needed basis to concerns. The facility DSD performs sequarterly abuse in-services, a in-services and on as needed. Resident council meetings ar monthly. The Activity Direct review resident rights during meetings. Any concerns iden forwarded to the DON or desfollow up. The DSD will report any non issues to the quality assurance.	ustomer care review their ded to the r designee on monthly form customer on services will o resolve any cheduled nnual respect basis. e held for (AD) will the tified will be signee for		

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		IDENTIFICATION NUMBER:	A, BUILO	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
056410			ti, WING	B, WING			07/20/2016	
	PROVIDER OR SUPPLIER Y OAKS CARE CENT			STREET ADDRESS, 3529 WALNUT AV CARMICHAEL,				
(X4) ID PREFIX TAG	BUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			K (EACH CO	DER'S PLAN OF CORRECT DRRECTIVE ACTION SHO FERENCED TO THE APPR DEFICIENCY)	ULDBE	(K5) COMPLETION DATE	
F 241	quickly stood up fr asked him not do then asked CNA 1 The facility's inten- indicated CNA 2 a positioning Reside were giving care, a pillow on Reside off and CNA 1 thr stated she noticed looked displeased Registered Nurse could talk to CNA with certain reside Resident A's daug back into Resider CNA 1's actions, thankful, but did n mother anymore.	rom where she was sitting an anything like that again. CNA to leave the room. If the with CNA 2, dated 1/21/1 sked CNA 1 to assist her intent A. CNA 2 stated while the CNA 1 was laughing and three ant A's face. Resident A three with beach on her again. CNA 1 Resident A's daughters face. CNA 2 stated she informed (RN) 1 of the incident so she 1 about not playing like that ents as CNA 2 could tell ghter did not like it. CNA 2 went A's room and apologized for Resident A's daughter was not want CNA 1 caring for her CNA 2 stated the daughter of CNA 1 interacted with her mot	A 2 PAN	41				
	at 12:45 p.m. She Resident A and it repositioned. CN help her. CNA 2 and "kid around," finished reposition the end of the bell A's legs and feet, pillow up to Reside and tossed it bac proceeded to tost landed near Resident A's dau.	lewed via telephone on 2/16/ e stated she was assigned to was time for her to be A 2 stated she asked CNA 1 stated CNA 1 likes to "play a CNA 2 stated after they ning Resident A, CNA 1 was a did putting pillows under Resident A that landed on Resident A that landed on Resident A took the pillow off her fact k to CNA 1. CNA 1 then is it back to Resident A and it dent A's head. CNA 2 stated ghter was present in the room if the daughter was not happy	to lot" at ent is a int ce	Facility ID: CA030000			eet Page 3 of 5	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING. 058410 07/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3529 WALNUT AVENUE WHITNEY OAKS CARE CENTER CARMICHAEL, CA 95608 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 241 Continued From page 3 F 241 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 "loked 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 Alagain. 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 "filipped 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

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FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 056410 B. WING 07/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3629 WALNUT AVENUE WHITNEY OAKS CARE CENTER CARMICHAEL, CA 95608 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XB) COMPLETION OATE ID. (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 241 Continued From page 4 F 241 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 I 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 3/21/18 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.