STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. BUILDING _____ B. WING _____	C 03/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH CARE	5901 LEMON HILL AVE SACRAMENTO, CA 95824

(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 number CA00432427. Representing the Department of Public Health: HFEN, 29825 The inspection was limited to the specific entity reported incident investigated and does not reflect the findings of a full inspection of the facility.	F 000	This Plan of Correction Constitutes our written credible allegation of compliance for the deficiencies noted. 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 on the statement of deficiencies. This 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 C.F.R. 483 et seq.	Accepted 3-26-15 aw
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement policies and procedures that prohibit abuse of residents when the facility was unable to find back ground and reference checks for Certified Nurses Aid (CNA) 1. This failure increased the risk for resident abuse. Findings: The personnel file for CNA did not contain a background check and there was no evidence references had been contacted prior to hire.	F 226	**F-226** **How Corrective Action will be accomplished for those residents found to have been affected by the deficient practice.** The Director of Staff Development (DSD) completed a background check for CNA 1 on 3/12/15.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary L Meyer — TITLE: NHA — (X6) DATE: 3/20/15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. BUILDING _____ B. WING _____	C 03/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH CARE	5901 LEMON HILL AVE SACRAMENTO, CA 95824

(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 226	Continued From page 1 An interview was conducted with the Director of Staff Development on 2/27/15 at 2:25 p.m. She said she could not find CNA 1's background or reference checks. They were unavailable to review. Review of the facility policy and procedure titled Background and Credit Checks, revised 9/2013, indicated, "Pre-Hire Background Checks:...8. If hired, the background report must be filed in a confidential file...Current Employee Background Checks: 1. Each employee will undergo a background check on a regular basis, no less than quarterly (4 times per year)."	F 226	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** The Director of Human Resources (DHR) completed an audit of personnel files on 3/9-10/15. The DSD completed quarterly background checks on employees per company policy on 3/31/15.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** Assistant Director of Clinical Services in-serviced the Director of Staff Development (DSD) on the background check policy on 3/12/15. DHR provided further education to the DSD regarding the background check policy on 3/10/15. DSD will complete background checks on employees upon hire and quarterly thereafter per company policy on 3/31/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. BUILDING _____ B. WING _____	C 03/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH CARE	5901 LEMON HILL AVE SACRAMENTO, CA 95824

(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 441	Continued From page 2 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review, the facility failed to maintain an Infection Control Program to provide a sanitary environment for 5 of 5 sampled residents when oxygen tubing was not labeled and/or not changed weekly. This failure increased the risk of respiratory infection in the facility. Findings: 1. Resident 1 was admitted to the facility with diagnoses including lung disease and low oxygen levels. Resident 1's care plan titled [Oxygen], dated 1/7/15, indicated the nasal cannula and humidifier bottle were to both be changed every Sunday. An interview was conducted with Licensed Nurse (LN) 1 during concurrent observation of Resident 1's oxygen tubing on 12/27/15 at 12:50 p.m. LN 1	F 441	**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.** The Administrator will verify the completion of a background checks on employees upon hire and quarterly thereafter. The Administrator will report any noncompliance at the quarterly Quality Assurance Committee. **Corrective action will be completed 3/31/15.** **F-441** **How Corrective Action will be accomplished for those residents found to have been affected by the deficient practice.** Licensed Nurse changed Residents 1-5 oxygen tubing and properly labeled on 2/27/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. BUILDING _____ B. WING _____	C 03/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH CARE	5901 LEMON HILL AVE SACRAMENTO, CA 95824

(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 441	Continued From page 3 verified there was no date on the oxygen equipment and said, "We usually put tape with the date on it." 2. Resident 2 was admitted to the facility with diagnoses including lung and heart disease. Resident 2's physician's orders, dated 2/28/15, indicated the oxygen tubing was to be changed weekly and as needed for soiling or excessive moisture. Resident 2's Treatment Administration Record (TAR), dated 2/2015, indicated, "[Oxygen at] 2-4 [liters per minute] via [nasal cannula as needed] (for) [shortness of breath]." It was not initialed for the entire month of February 2015. There was no indication the tubing had been changed. An interview was conducted with LN 1 during concurrent observation of Resident 2's oxygen tubing on 2/27/15 at 12:53 p.m. LN 1 verified the tubing was labeled 1/19/15 on paper tape attached to the tubing. It indicated the tubing had not been changed in more than 5 weeks. An interview was conducted with the Director of Nurses (DON) during concurrent review of Resident 2's TAR on 2/27/15 at 1:15 p.m. The DON said Resident 2's oxygen order was to be given as needed and she could not tell when the tubing had been changed. It was not initialed. 3. Resident 3 was admitted to the facility with diagnoses including lung disease. An observation of Resident 3's oxygen setup was conducted on 2/27/15 at 12:45 p.m. The oxygen tubing was dated 1/19/15 on paper tape attached	F 441	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** The other residents on oxygen therapy are at risk of this practice as they are on the same tubing change schedule. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** The DON provided an in-service to the licensed nurses regarding the proper oxygen tubing changing, storage and labeling on 3/12/15. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.** The DSD or DON will complete weekly audits to ensure that the oxygen tubing has been changed every Monday x 4 weeks and then randomly thereafter. The DSD will report any noncompliance to the quarterly Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. BUILDING _____ B. WING _____	C 03/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH CARE	5901 LEMON HILL AVE SACRAMENTO, CA 95824

(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 441	Continued From page 4 to the tubing. Resident 3's physician orders, dated 9/2/2012, indicated oxygen tubing and the humidifier bottle were to be changed every week on Sunday. An interview was conducted with the Director of Staff Development (DSD) during concurrent observation of Resident 3's oxygen tubing on 2/27/15 at 12:50 p.m. The DSD verified the paper tape on the oxygen tubing was dated 1/19/15. It indicated the tubing had not been changed in more than 5 weeks. An interview was conducted with the DON during concurrent review of Resident 3's TAR on 2/27/15 at 1:15 p.m. The DON verified it had been initialed as changed 2/22/15. There was a discrepancy from the label on the tubing and the documentation in Resident 3's clinical record. 4. Resident 4 was admitted to the facility with diagnoses including lung and heart disease. Resident 4's physician orders, dated 10/31/2014, indicated the oxygen tubing and humidifier bottle was to be changed every week on Sunday night. Resident 4's care plan titled Potential; for Injury [related to] Non-compliance as Evidenced by Removal of Oxygen Equipment, dated 8/5/14, indicated, "Oxygen tubing has to be changed every week and as needed." An interview was conducted with LN 1 during concurrent observation of Resident 4's oxygen tubing on 2/27/15 at 1:02 p.m. No date was found on the oxygen tubing. LN 1 said "We usually put tape with the date on it."	F 441	**Corrective action will be completed by 03/31/15.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. BUILDING _____ B. WING _____	C 03/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH CARE	5901 LEMON HILL AVE SACRAMENTO, CA 95824

(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 441	Continued From page 5 An interview was conducted with the DON during concurrent review of Resident 4's TAR on 2/27/15 at 1:15 p.m. The DON verified the TAR had been initialed 2/22/15 indicating the tubing had been changed. There was a discrepancy between the observation and record. 5. Resident 5 was admitted to the facility with diagnoses including lung and heart disease. Resident 5's physician's orders, dated 10/20/2011, indicated the oxygen tubing and humidifier bottle were to be changed every week on Sunday. Resident 5's care plan titled [Resident name] has oxygen therapy [related to] Chronic Airway Obstruction with Oxygen Saturation of 85-87% on Oxygen [at] 3 [liters per minute] via [nasal cannula], dated 5/3/13. It indicated "Tubing is always clean and replaced routinely every week and as needed..." Resident 5's TAR, dated 2/2015, indicated "Change [oxygen] tubing and humidifier bottle [every] Week on Sunday". An interview was conducted with Certified Nurses Aid (CNA) 2 during concurrent observation of Resident 5 in the dining room on 2/27/15 at 1:38 p.m. CNA 2 verified the nasal cannula to the oxygen was not labeled.	F 441		