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

ED: 06/11/2013
RM APPROVED
O. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD B. WING	ATE SURVEY OMPLETED
	555635		C 5/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD CARE CENTER	340 NORTHLAKE DRIVE SAN JOSE, CA 95117

(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 (CDPH) during an abbreviated standard survey for an entity reported incident conducted on 5/29/13. Entity Reported Incident CA00355619 regarding Quality of Care Treatment was substantiated, and a Federal deficiency was identified (see F309). Inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. Representing the CDPH: 25460, Health Facilities Evaluator Nurse.	F 000	*This plan of correction is the center's credible allegation of compliance. 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 federal and state laws.* CALIFORNIA DEPARTMENT OF PUBLIC HEALTH JUN 25 2013 L & C DIVISION SAN JOSE	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide alternative interventions or approaches in an effort to prevent further resident to resident altercations for one of two sampled residents (1). Resident 1 had of the behavior of kicking and hitting other residents and staff. The facility failed to attempt to identify possible factors	F 309	**F309 Provide Care/Services For Highest Well Being** It is the policy of Courtyard Care Center to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care. **Corrective Action** On 5/29/13 the Inter-disciplinary Team (IDT) met to discuss what causes Resident 1's aggressive behaviors and possible interventions to prevent/reduce recurrence of behaviors. In addition, staff observed for other reasons that trigger his behavior. Resident 1 is territorial at the front lobby and the dining room. There are certain	5/29/13

LABO[redacted] RESENTATIVE'S SIGNATURE [redacted] TITLE ADMINISTRATOR (X6) DATE 6/24/13

Any d[redacted]otes 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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	555635	A. BUILDING _____ B. WING _____	C 05/29/2013

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F 309	Continued From page 1 that may underlie the resident's physical aggression. Findings: Resident 1's 4/23/13 Minimum Data Set indicated he was able to express himself if prompted or given time. He could comprehend clearly. He was wheelchair bound and did not walk. The 7/19/12 care plan indicated Resident 1 exhibited behavioral symptoms as evidenced by physical abuse and socially inappropriate behavior. The 1/5/13 care plan indicated Resident 1 demonstrated behavioral episodes of hitting and kicking residents and staff. The 5/21/13 social services notes indicated Resident 1 had kicked another resident and was sent to the acute care hospital. The 4/24/13 interdisciplinary (IDT) notes indicated Resident 1 had an altercation with another resident, and the plan was to transfer the Resident 1 to another facility. The 7/5/12 IDT notes indicated the plan was to transfer Resident 1 to another facility. On 5/29/13 at 1:30 p.m., certified nursing assistant A (CNA A) stated on 5/21/13, during lunchtime, Resident 1 was seated in the wheelchair in the dining room near Resident 2. CNA A stated Resident 1 wheeled himself towards Resident 2 and twice kicked Resident 2 on his left leg without any provocation. CNA A stated she separated both residents and took Resident 2 to the nursing station to be assessed by the charge nurse. CNA A stated Resident 1 would not answer questions related to the incident and Resident 1 was sent to acute care hospital after the incident.	F 309	residents who irritate him and he does not want them in close proximity. He does not like the fan turned on in the dining room. He wants to be served a meal first before other residents. He wants CNA's to attend to him immediately when he presses the call light. Resident 1's care plan was revised and updated on 5/30/13. Facility will provide him with space at one corner of the lobby, away from other residents, in presence of staff. We have identified residents who irritate him and will separate them from Resident 1. Staff will closely supervise his whereabouts. We will assign him at a table at least one arm's length away from other residents in the dining room. Staff will accompany him to and from the dining room and ensure there is a receiving staff when he arrives in the dining room. We will turn off the fan that is located by his table in the dining room. Staff will serve him a meal tray before other residents. Staff will respond to his call lights in a prompt manner. Moreover, facility will provide him with one-on-one sensory stimulation activities such as (but not limited to) aromatherapy, relaxation music, and strolls outside to calm him down. Facility will arrange to obtain the services of a social worker or psychologist to teach resident relaxation methods and anger management techniques. These interventions will be done no later than 6/29/13.	5/30/13 6/29/13

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F 309	Continued From page 2 On 5/29/13 at 2:47 p.m., during an interview with Resident 1, with an interpreter, Resident 1 did not recall kicking another resident. Resident 1 looked angry and shook his head while talking to the interpreter. The interpreter stated the resident was angry, saying bad words and swearing. During an interview on the same date and time, CNA B stated Resident 1 kicked others to show his anger towards them. CNA B stated he tried to talk to the resident in an effort to calm him down whenever he displayed such behavior. If the resident did not calm down, he would inform the nurse, and they would give Resident 1 medications. CNA B stated he did not know what caused Resident 1's anger. On 5/29/13, review of the care plan approaches/interventions for the kicking and hitting behavior indicated to approach the resident in a calm, friendly manner; redirect as needed; administer medications, refer for a psychiatric evaluation when needed; observe the resident's behavior frequently and to encourage activities and staff visits. There was no documentation of the effectiveness of the approaches/interventions addressed by the IDT team during the review of the care plan. On 5/29/13 at 3:40 p.m., during an interview and record review with the director of nursing (DON), the care plans dated 7/19/12, 1/15/113 and 5/21/13 were reviewed. Resident 1 exhibited physical aggression manifested by kicking and hitting residents/staff. The care plans did not include other possible alternative approaches despite recurrent episodes of kicking and hitting.	F 309	**Other Residents Affected** All residents residing in the facility have the potential to be affected by this deficient practice. **Systemic Changes** Director of Nursing (DON) will conduct in-service to staff on identification, behavior management, supervision, and monitoring of the resident no later than 6/29/13. From 5/30/13 and moving forward, IDT will identify interventions and approaches of any resident concerns during the daily morning stand-up meetings. Any concerns during the weekends will be discussed the following workday. **Monitoring** Staff will closely supervise Resident 1's whereabouts on a daily basis. Floor staff will report to charge nurse any observation of aggressive behavior and its possible cause. Social Services Director (SSD) or designee will meet with the resident weekly for follow up. DON or designee will review resident concerns with SSD on a weekly basis to ensure that concerns are addressed by the IDT. She will report findings in the daily morning stand-up meeting for discussion, planning, and correction. She will identify trends and report them during the monthly Quality Assurance and Performance Improvement for evaluation and resolution. **Completion Date**	6/29/13 5/30/13 AND ON-GOING 5/30/13 AND ON-GOING 6/29/13

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F 309	Continued From page 3 The DON stated Resident 1's behavior was unpredictable. She stated when Resident 1 physically harmed others the facility transferred him to the acute care hospital for further evaluation. The DON stated the facility also followed the abuse protocol for resident altercations. The DON stated she would meet with the IDT and plan other approaches including attempting to identify the causative factors of Resident 1's aggressive behaviors. This would assist staff in providing individualized interventions in an effort to prevent recurrence or to reduce the incidence of behaviors. DON stated she would initiate a monitoring process to ensure staff observed Resident 1 for any potential situational or environmental reasons that might trigger his aggressive behavior.	F 309	The alleged deficient practice will be completed by 6/29/13.	6/29/13