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

PRINTED: 07/25/2013
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
	555673	A. BUILDING _____ B. WING _____	C 07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825 OK MB 8/12/13

(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 standard survey for the investigation of entity reported incident #CA00357423. Representing the Department of Public Health: HFEN 29825 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000	F323 The resident has not received any PRN intramuscular or oral psychoactive drug due to aggression, combativeness since 5/31/13. The nurses that care for this resident have been in serviced on the need to monitor side effects if an psychoactive medication is administered due to his aggression.	8/15/13
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of clinical records, policies and procedures, the facility failed to ensure adequate supervision when Resident 1 when he fell fracturing his wrist. This failure had the risk of harm to Resident 1. Findings: Resident 1 was admitted to the facility on 11/14/12 with diagnoses including dementia and schizophrenia. Review of his 30 day Minimum	F 323	Any resident that exhibits signs of aggression, assaultiveness, or combativeness that is in need of a psycho active drug administered orally or via I.M. shall be observed for side effects like lethargy, falling, dizziness, sedation, ataxia muscular incoordination, confusion, drowsiness, disorientation, paradoxical agitation, excitement or rebound anxiety. There have been no resident that has exhibited signs of aggression or combativeness since 5/31/2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/8/13

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 323	Continued From page 1 Data Set (an assessment tool), dated 12/14/12, revealed Resident 1 cognitive state was severely impaired and he required extensive assistance with his Activities of Daily Living. He usually understood others and could make himself understood. During an attempted interview with Resident 1 on 6/12/13 at 11:34 a.m. there was no understandable response. Review of physician telephone orders for Resident 1, dated 5/17/13, indicated "...Ativan [a medication given for anxiety] 1 mg [milligram, a unit of dose] / IM [intramuscular] Q [every] 12 [hours] prn [as necessary] anxiety M/B [manifested by] restlessness..." Review of Resident 1's document Physician Orders, dated 5/17/2013, indicated "Ativan, monitor side effects of antianxiety meds...dizziness, sedation, ataxia...muscular incoordination, confusion, drowsiness, disorientation...paradoxical agitation or excitement, rebound anxiety..." Review of Resident 1's Medication Record (MR), dated 5/17/13 indicated Ativan was given for increased agitation and combativeness on 5/31/13. On the back side of the document "Nurses Medication Notes" documented Ativan was given at 10:00 (a.m.) for agitation and combativeness with the result "helped" noted at 11:00 (a.m.). The MR did not indicate that behavior and side effects were to be monitored for Ativan. Review of Resident 1's Nurses Notes, dated	F 323	Licensed staff shall be inserviced by the Director of nursing and director of staff development to monitor side effects of a newly provided psychoactive drug for combativeness or aggression. Any resident that was provided the oral or IM drug will be flagged in the 24 hour report and reviewed the following day by clinical managers and supervisors. The monitoring shall be documented in the MAR. Residents receiving psychoactive drugs exhibiting behaviors will have their MAR reviewed to ensure that supervision is documented and that the physician order was followed. Results of audits will be directed to the Quality Assurance and Assessment Committee for review and action. The DNS shall report this to the QAAC. This shall be accomplished by August 15, 2013.	8/15/13

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F 323	Continued From page 2 5/31/13 at 13:00 (1 p.m.) described how, after the fall, "He had taken his tab alarm off & placed it on the W/C [wheel chair] so it was not alarming." After the fall, he complained of pain in his right hip and left wrist. Review of Resident 1's History and Physical, dated 6/7/13, confirmed he had sustained a left wrist fracture during the 5/31/13 fall from his wheel chair. During an interview with CNA 1 on 6/28/13 at 9:42 a.m., she stated " He wasn't safe to get up alone. Sometimes he'd pull the tab alarm off. I think it [a 1:1 sitter] would help safety wise..." During an interview on 6/12/13 at 12:08 with CNA 2, she stated, "He's known to get up out of his chair...[He] takes the tab alarm off and throws it." During an interview with Licensed Nurse (LN) 2 on 6/12/13 at 11:45 a.m., she said she gave Ativan "earlier that day" (10:00 a.m.) for increased agitation and combativeness and later walked by the room of Resident 2 where she saw he was laying on the floor on his left side. During a later interview on 7/1/13 at 2:24 p.m., LN 2 also revealed "He would try to get up out of his wheel chair [in the hallway] to get to his room... There was no one watching him 1:1 that day". During an interview with the Director of Nurses (DON) on 7/23/13 at 11:53 a.m., she explained no one was specifically allocated to monitor Resident 1 following the administration of the Ativan on 5/31/13. All staff (in the area) were supposed to monitor him and it was mealtime when CNA's were giving care to other residents and going to	F 323		8/15/13

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F 323	Continued From page 3 lunch. Review of the facility policy and procedure titled "Behavior Assessment and Monitoring", revised April 2007, established "3. The nursing staff....will monitor for side effects and complications related to psychoactive medications; for example lethargy...or recurrent falling."	F 323		8/15/13