POC accepted by [redacted] 8/27/12

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

PRINTED: 08/15/2012
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 |
|---|---|---|---|
| | 056048 | A. BUILDING _____ B. WING _____ | C 07/17/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PACIFIC COAST MANOR | 1936 WHARF ROAD CAPITOLA, CA 95010 |

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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during an abbreviated standard survey regarding two entity reported incidents conducted on 7/17/12.<br><br>For Entity Reported Incident CA00316963 regarding Quality of Care/Treatment, Federal deficiencies were identified (Code of Federal Regulations, F241 and F279).<br><br>For Entity Reported Incident CA00316965 regarding Resident Abuse, Federal deficiencies were identified (Code of Federal Regulations, F241 and F279).<br><br>Inspection was limited to the specific ERIs investigated and does not represent the findings of a full inspection of the facility.<br><br>Representing the California Department of Public Health was 29260, Health Facilities Evaluator Nurse. | F 000 | Preparation and/or execution of this plan of correction does 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 as required by the provisions of Health and Safety Code, Section 1280 and 42 C.F.R. 483.<br><br>CALIFORNIA DEPARTMENT OF PUBLIC HEALTH<br>AUG 21 2012<br>L & C DIVISION SAN JOSE | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to treat two of three sampled residents (1 and 2) with dignity and respect when Resident 1 alleged certified nurse | F 241 | | |

Rev'd

[redacted] TITLE (X6) DATE 8/20/12

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<br>assistant A (CNA A) was rough with her and caused a bruise to the top of her right hand. Also, Resident 2 alleged CNA A was rough with her when he threw her remote control and a plate cover, hitting her leg and causing bruises. Resident 2 further alleged CNA A swore at the chair she was sitting in, threw items on her bed, and disrespected her personal items. Findings:<br><br>1. Resident 1 was admitted with diagnoses including arthritis (painful, inflammatory joints). Resident 1's clinical record was reviewed on 7/17/12.<br><br>Resident 1's minimum data set (MDS, an assessment tool) dated 6/29/12 indicated she was cognitively intact. It further indicated she need extensive assistance with transfers and activities of daily living (ADLs).<br><br>During an interview and observation on 7/17/12 at 7:05 a.m. of Resident 1 while she was lying in her bed, a black and red bruise was observed on the top of her right hand. Resident 1 stated about three weeks ago certified nurse assistant A (CNA A) was rough and grabbed her by the hand and stated his [CNA A's] thumb hit her "here," pointing to the bruise on the top of her right hand. Resident 1 further stated CNA A had his thumb on her hand and "put a lot of pressure" on it when he swung her legs off the bed. Resident 1 stated CNA A told her she was "too heavy" for him. She stated during her shower he turned her around in the chair to rinse her off fast. She stated after she was done with her shower, CNA A stood her up and pulled the commode chair out from under her before "I can get my balance." Resident 1 further stated she ignored CNA A's roughness "a | F 241 | F241 #1<br><br>Training regarding transfer and handling techniques and treating residents with respect will be completed for Resident #1's caregivers. (CNA A no longer works at the facility) CNA's caring for other residents will be inserviced regarding transfer and handling techniques and resident dignity to ensure other residents are handled properly and treated with respect and dignity. Follow-up for resident bruising and resident reporting will continue to be monitored per facility policy. The Director of Staff Development will monitor proper handling compliance through observation and by asking 10% of the residents per month regarding their satisfaction with transfers, handling techniques and respectful treatment. The DSD will present findings to the Quality Assurance Committee monthly. | 8/31/12 |

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| F 241 | Continued From page 2<br>lot of times, but this was the straw that broke the camel's back. It was too much."<br><br>Record review was conducted on 7/17/12 at 10:26 a.m. "IDT Post-Occurrence Review" dated 7/6/12, indicated Resident 1 reported bruising to the top of her right hand, approximately 3 x 4 centimeters (cm) in size. It further indicated Resident 1's alleged bruising resulted from a transfer during activities of daily living (ADLs) on 7/4/12 and was reported by the resident to staff on 7/6/12.<br><br>A "Report of Incident SBar-Physical Injury" dated 7/6/12, indicated Resident 1 had a bruise or discoloration located on her top right hand and it was from an "Injury During ADL Care." The size of the wound/injury was documented as 3 cm long by 4 cm wide.<br><br>"Nurses Progress Note & Care Plan" dated 7/6/12, indicated a certified nurse assistant (CNA) informed a nurse Resident 1 had a purple discoloration on the top of her right hand and stated a previous CNA had caused the bruise during ADL care.<br><br>During an interview on 7/17/12 at 10:35 a.m., licensed nurse B (LN B) stated she was told by certified nurse assistant C (CNA C) Resident 1 had a bruise on her right hand and stated CNA A had caused it.<br><br>During an interview on the above date at 10:45 a.m., CNA C stated she had her day off and when she returned she noticed the bruise on Resident 1's hand. She further stated Resident 1 stated CNA A had held her hand too hard. She stated | F 241 | | |

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| F 241 | Continued From page 3<br>Resident 1 told CNA A to be gentle with her and he replied to Resident 1, she was too heavy. CNA C then stated she needed to report this information to her nurse and Resident 1 should tell the nurse "everything that happened."<br><br>2. Resident 2 was admitted with diagnoses including degenerative arthritis (inflammation of a joint). Resident 2's clinical record was reviewed on 7/17/12.<br><br>Resident 2's MDS dated 6/15/12 indicated she had no cognitive impairment. It further indicated she needed extensive assistance with most ADLs.<br><br>During an interview on 7/17/12 at 8:35 a.m., Resident 2 stated a couple of months ago, CNA A threw her remote control. It hit her leg and bruised it. Resident 2 stated CNA A removed her clothes from the closet for the day and threw them on the bed. When Resident 2 asked CNA A to have some respect for her clothes, she stated CNA A just laughed. Resident 2 also stated CNA A swore at the chair she was sitting on a couple of weeks ago and he threw a plastic plate cover on her leg, causing another bruise to her leg. Resident 2 stated CNA A also threw piles of towels on the bed.<br><br>During an interview on 7/17/12 at 8:45 a.m., Resident 2 stated CNA A wanted her to have her clothes ready for the day and did not want to wheel her on the commode to the closet to pick out her clothes. Resident 2 stated CNA A would ask, "What costume do you want to wear today?" She stated CNA A's style was rough. | F 241 | 241 #2<br><br>Training regarding proper handling of resident's belongings will be completed for Resident #2"s caregivers. (CNA A no longer works at the facility)To ensure compliance for other residents, CNA's will be inserviced by the Director of Staff development regarding proper and respectful handling of resident belongings. Followup for resident bruising and resident reporting will continue to be monitored per facility policy. Compliance will be evaluated each month by the Director of Staff Development by interviewing 10% of the residents regarding their satisfaction with staff handling of their belongings. The Director of Staff Development will present findings to the Quality Assurance Committee each month. | 8/31/12 |

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| F 241 | Continued From page 4<br>During review on 7/17/12 at 11:45 a.m., of "Report of Incident SBar - Physical Injury," dated 7/6/12, it indicated Resident 2 had scattered red areas over 1/2 of her left leg and 1/3 of her right leg. The progress note included in the above report indicated Resident 2 stated scattered red/purple erythema was "caused by ADL care over the past 3-6 months."<br><br>During an interview on 7/17/12 at 7:40 a.m. with the executive director (ED), she stated Resident 2 complained CNA A was always rushed, in a hurry, stressed out and careless. She further stated the remote control got tossed on Resident 2's leg. Another time Resident 2 stated CNA A cussed in front of her.<br><br>Review on 7/17/12 at 1:30 p.m. of "Residents' Rights" policy revised 01/01, indicated, "Each resident must be treated with respect . . . Employees are expected to protect the rights of each resident at all times." It further indicated, "Each resident has the right to have their belongings treated with respect . . ." | F 241 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. | F 279 | | |

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| F 279 | Continued From page 5<br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to develop activities of daily living (ADL) care plans including the level of assistance for transferring the resident for two of three sampled residents (1 and 2). These omissions could potentially result in unsafe transfers and injuries to residents. Findings:<br><br>1. Resident 1 was admitted with diagnoses including arthritis (painful, inflammatory [swollen] joints). Resident 1's clinical record was reviewed on 7/17/12.<br><br>Resident 1's minimum data set (MDS, an assessment tool) dated 6/29/12 indicated she was not cognitively impaired. It further indicated she needed extensive assistance with transfers.<br><br>An "Activities of Daily Living (ADL)" care plan dated 9/21/11, indicated Resident 1's transfer instructions were not listed on the care plan.<br><br>During an interview on 7/17/12 at 8:50 a.m. with licensed nurse D (LN D), she asked the vocollect (head set system telling staff specific care | F 279 | F279#1<br><br>Resident #1's care plan and Vocollect have been updated to include transfer instructions. All residents will have their care plans and Vocollect audited by the nursing supervisors to ensure the inclusion of each resident's transfer instructions by the unit supervisors.Care plans found to be insufficient will be corrected. Licensed Nurses will be inserviced by the Director of Nursing regarding updating care plans and Vocollect accuracy. Nursing unit supervisors will audit 10% of the residents monthly for the inclusion of transfer instructions on the care plan and Vocollect. Findings will be presented by the nursing supervisors at the monthly Quality Assurance Committee. | 8/31/12 |

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| F 279 | Continued From page 6<br>instructions for each resident) to review transfer instructions for Resident 1. LN D stated there was "no transfer care required."<br><br>During an interview on the above date at 9 a.m., licensed nurse E (LN E) stated transfer instructions for Resident 1 should be on her ADL care plan and was not. She further stated there were no vocollect instructions for transfer of Resident 1.<br><br>Resident 1's "Nurse's Notes" dated 7/6/12 at 2230, indicated the licensed nurse reminded CNAs to be careful when assisting Resident 1 with her ADLs.<br><br>Review of Resident 1's care plan for bruising dated 7/6/12 indicated there were no updated approaches listed for direct care staff to handle the resident gently during ADL care.<br><br>2. Resident 2 was admitted with diagnoses including degenerative arthritis (inflammation of a joint). Resident 2's clinical record was reviewed on 7/17/12.<br><br>Resident 2's MDS dated 6/15/12 indicated she had no cognitive impairment. It further indicated she needed extensive assist with transfers.<br><br>An "Activities of Daily Living" care plan dated 6/11/11, indicated Resident 2's transfer instructions were not listed on the care plan.<br><br>During an interview on 7/17/12 at 1:15 p.m., the ED stated there were no transfer instructions noted on ADL care plans for Resident 1 or 2. | F 279 | F279#2<br><br>Residents #1 and #2 have had their care plans updated to include transfer instructions. All residents will have their care plans evaluated by the nursing supervisor for inclusion of transfer instructions. Any care plans found to be insufficient will be corrected. Licensed Nurses will be inserviced by the Director of Nursing regarding the process of updating care plans for transfer instructions. Nursing supervisors will audit 10% of the residents monthly for inclusion of transfer instructions on the care plan. Findings will be presented at the monthly Quality Assurance Committee by the nursing supervisor. | 8/31/12 |

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| F 279 | Continued From page 7<br>3. During an interview on 7/17/12 at 8:35 a.m., Resident 2 stated a couple of months ago, CNA A threw her remote control. It hit her leg and bruised it. Resident 2 also stated CNA A threw a plastic plate cover on her leg, causing another bruise to her leg.<br><br>During review on 7/17/12 at 11:45 a.m., of "Report of Incident SBar - Physical Injury," dated 7/6/12, it indicated Resident 2 had scattered red areas over 1/2 of her left leg and 1/3 of her right leg. The progress note included in the above report indicated Resident 2 stated scattered red/purple erythema was "caused by ADL care over the past 3-6 months."<br><br>Review of Resident 2's care plan for bruising dated 7/6/12 indicated there were no updated approaches listed for direct care staff to handle the resident gently during ADL care.<br><br>During an interview on 7/17/12 at 10:15 a.m., the executive director (ED) stated it would be a good care plan intervention to have CNAs be careful with residents during ADL care.<br><br>Review on 7/17/12 at 2 p.m. of policy, "Care Plan, Comprehensive" dated 2008, indicated, "The care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life . . .It is reviewed and revised . . .quarterly . . ." It further indicated, "The Care Plan is individualized by identified resident problems . .Resident progress is regularly evaluated in each category with approach revisions and updates as appropriate. . ." | F 279 | F279 #3<br><br>Resident #2 has had her care plan updated to include that staff will encourage her to communicate preferences regarding ADL care and transfers. It is a facility expectation that staff will be gentle with residents. The care plans for all residents that have had bruising in the last 30 days will be reviewed by the nursing supervisorto ensure that there is a current approach regarding handling during ADL care. Licensed Nurses will be inserviced by the Director of Nursing regarding the process of updating care plans with handling instructions. Resident's care plans with bruises will be audited for appropriate approaches by the unit supervisor each month.Findings will be reported by the unit supervisors to the Quality Assurance Committee monthly. | 8/31/12 |