STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555083	A. BUILDING _____ B. WING _____	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKATON CARE CENTER MANZANITA	5318 MANZANITA AVENUE POC acceptable 7/27/17 CARMICHAEL, CA 95608 P.S. Pinkham HFES

(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 annual recertification survey. Representing the Department of Public Health: HFEN, 17069 HFEN, 26367 HFEN, 36544 HFEN, 38518 The facility census was 91 with 19 sampled residents.	F 000	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 Federal and State Law. This response and plan of correction constitutes the facility's allegation of compliance in accordance with applicable codes of the State Operations Manual	
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must-	F 221	**F221** **Affected Resident:** The noted wheelchair and table were moved to allow resident 11 freedom of movement. **Potentially Affected Resident:** All residents unable to independently move items such as wheelchairs and tables are potentially affected. **Correction:** The direct care giver, CNA #1, was interviewed and instructed on what constitutes a restraint. The facility's DSD or designee will inservice all direct care staff on what constitutes a restraint.	6/18/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	6/9/17

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 221	Continued From page 1 (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect 1 of 19 sampled residents (Resident 11) from the use of restraints when a staff member blocked off the sides of the resident's bed to prevent her from rising from the bed unassisted. This failure had the potential to increase Resident 11's risk of injury; through entrapment. Findings: Resident 11 was admitted to the facility in 2012. Her diagnoses included history of falls. A 2/10/14 care plan for "Falls" indicated Resident 11 was at greater risk of experiencing a fall related to her history of falling, dementia, and use of antipsychotic medications. An Event Report from 9/9/16 indicated Resident 11 fell in her room between the bed and her wheelchair. An Event Report from 9/10/16 indicated Resident 11 had a witnessed fall. An Event Report from 11/1/16 noted Resident 11	F 221	**F221 Correction, cont.:** Additionally, the DSD will include in her schedule an inservice regarding restraints, at a minimum, of twice annually. **Monitoring:** The facility's Unit Managers, and/or their designee will review all patients for fall risk to insure compliance with a restraint free environment. These reviews will be documented for a period of three months and the findings of these reviews will be presented as a summary report to be submitted to the QA Patient Safety committee at the quarterly meeting.	

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F 221	Continued From page 2 had a witnessed fall in the hallway. An Event Report from 1/21/17 noted Resident 11 was observed on the floor in her room. An Event Report from 4/11/17 indicated Resident 11 had an assisted fall to the floor in her room. The facility's 3/1/05 policy titled "Restraints-Physical" indicated, "Physical Restraints are defined by the Centers for Medicare and Medicaid Services as any manual method, or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The policy further indicated devices used in conjunction with a chair, such as trays and tables that the resident cannot easily remove and prevent the resident from rising were considered restraints. In the event a restraint was needed, the Interdisciplinary Team (IDT) would assess the resident before initiating the restraint, obtain a physician order for the restraint, and establish a treatment plan for the restraint. There was no evidence in Resident 11's clinical record the IDT assessed her, obtained physician orders, or prepared a plan of care for the use of restraints to prevent Resident 11 from rising from her bed. Resident 11 was observed in her bed on 5/15/17 at 11:45 a.m. The left side of the bed was placed against the wall. On the right side of the bed a one-third length bed-side rail was raised along the top third of the bed. The bed-side table was placed along the middle third of the bed and	F 221		

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F 221	Continued From page 3 Resident 11's wheelchair was placed along the bottom third of the bed. A padded floor mat was pushed away from the right side of the bed. In an interview with Certified Nursing Assistant 1 (CNA 1) on 5/15/17 at 11:45 a.m., she reported she placed the table and the wheelchair next to the bed because Resident 11 would try to get out of the bed without assistance if she left an "opening" along the side of the bed. In an interview with Licensed Nurse 3 (LN 3) on 5/15/17 at 11:50 a.m., LN 3 observed the equipment up against Resident 11's bed and reported Resident 11 was at risk of experiencing a fall, and the padded mat that was pushed away from the side of the bed was supposed to be along the bed to protect Resident 11 in the event she fell from the bed. LN 3 verified the equipment placed along the side of the bed prevented the resident from easily rising from her bed.	F 221		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure the nurse call lights (the devices used by the residents to communicate a need to the facility staff) were positioned within reach for	F 241	**F 241** **Affected Residents:** As noted in the 2567 the call lights in question were repositioned for each resident. **Potentially Affected Residents:** All residents unable to independently access their respective call light are potentially affected by this POC.	6/18/17

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F 241	Continued From page 4 two of 19 sampled residents, (Resident 9 and Resident 14) when: 1. Resident 9's call light was tightly wedged between the raised bed rail and lower part of the mattress; and 2. Resident 14's call light was wrapped around the raised left bed rail when Resident 14 was sitting in the wheelchair on the opposite side of the bed. This failure decreased to ability of Resident 9 and Resident 14 to communicate their needs to facility staff and had the potential to contribute to unmet care needs. Findings: 1. Resident 9 was readmitted to the facility on 4/23/17 with diagnoses of quadriplegia (total or partial inability to move all four extremities). During the Initial Tour of the facility, on 5/15/17 at approximately 8:50 a.m., Resident 9 was observed to have movement only with his left arm and hand. The nurse call light was not observed within reach. During a concurrent interview with Resident 9, on 5/15/17 at 8:50 a.m., he relayed that he did not know where his nurse call button was located. In an interview with Certified Nurse Assistant 3 (CNA 3), on 5/15/17 at approximately 8:50 a.m., she stated "the call light should be across Resident 9." During a concurrent observation on 5/15/17 at 8:50 a.m., CNA 3 found the call light wedged	F 241	**F 241 Continued:** **Correction:** The facility's DSD or her designee will conduct a series of inservices for all direct care staff regarding the requirement of call light access appropriate to the needs of each resident and in accord with the specific plan of care. **Monitoring:** A random inspection will be conducted by the RN supervisor of each shift for 5 of 7 days per week for a period of one month commencing within the "completion date" noted on this POC. The results of these inspections will be documented and reviewed at the quarterly Patient Care meeting. A redacted report of the findings of these reviews will be made available during the appropriate Resident Council meeting – a record of this review will be included in the resident council minutes.	

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F 241	Continued From page 5 between the bed rail closest to the wall and the bed mattress. She tugged the call light cord out and positioned the nurse call light across the chest of Resident 9 so it was easily accessible with his left hand. 2. Resident 14 was admitted on 4/4/17 and had a diagnoses including diabetes. During the Initial Tour of the facility, on 5/15/17 at approximately 8:15 a.m., Resident 14 was observed sitting up in her wheelchair on the side of the bed closest to the room entrance and exit door. During a concurrent observation and interview with Licensed Nurse 4 (LN 4) on 5/15/17 at 8:15 a.m., the nurse call light was observed wrapped around the opposite bed rail away from Resident 14. Resident 14 stated "I'm blind and everything is in a haze." During an observation on 5/15/17 at approximately 8:15 a.m., LN 4 unwrapped the call light cord from the bed rail, walked around the bed and placed the call light across the chest and into the hand of Resident 14. In an interview with LN 4 on 5/15/17 at 8:15 a.m., she stated the call light was not properly placed for Resident 14 and should have been placed within reach. The clinical record care plan problem for Resident 14, dated 4/9/17, indicated, "Resident has impaired vision R/T [related to] H/O [history of] CANCER OF EYE. RESIDENT IS LEGALLY BLIND." [sic]. The care plan's long term goal indicated, "Resident will be free from negative	F 241		

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F 241	Continued From page 6 consequences of vision loss as evidenced by: remaining physically safe..." A care plan approach aimed to all disciplines indicated "Keep call light in reach at all times." The facility policy and procedure titled "Call Light System," revised 03/05/02, indicated, "Each resident will be provided the means to communicate their immediate needs with the staff...and "Each resident will have their call light system within reach while in their room and call system will be adapted per resident functional status as needed."	F 241		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 279	**F 279** **Affected Resident:** Resident 11's care plan has been updated to document/record the use of a "landing pad" [fall mat] as an intervention to prevent injuries in the event of a fall. **Potentially Affected Residents:** All residents at risk for falls, and who are identified via the IDT process (outlined in correction below) as potentially benefiting from the placement of a "fall mat" are potentially affected by this POC. **Correction:** All residents will be reviewed by the Fall Prevention IDT for appropriate intervention and associated care plan to prevent injury inclusive of the placement of a fall mat. The facility's Medical Records department will audit, via the list of	6/18/17

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F 279	Continued From page 7 (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 19	F 279	**F 279 Correction cont.:** residents provided by the Fall Prevention IDT, once per week for a four week period commencing during the "completion period" noted on this POC. **Monitoring:** The facility's Fall Prevention IDT will present the findings of the above interventions and audits to the quarterly QAPI Patient Care committee for review and necessary follow up.	

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F 279	Continued From page 8	F 279		

sampled residents (Resident 11) care plan identified all of the services Resident 11 needed when the use of a landing pad to prevent injuries during falls was not identified on her plan of care. This failure increased Resident 11's risk of injury during a fall.

Findings:

Resident 11 was admitted to the facility in 2012. Her diagnoses included history of falls.

A 2/10/14 care plan for "Falls" indicated Resident 11 was at greater risk of experiencing a fall because of her history of falling, dementia, and use of antipsychotic medications. There was no documented evidence the fall care plan directed staff to place a fall mat next to Resident 11's bed to prevent injury in the event she did fall from the bed.

An Event Report from 9/9/16 indicated Resident 11 fell in her room between the bed and her wheelchair. Resident 11 was sitting on the padded floor mat next to her bed and she was not injured as a result of the fall.

An Event Report from 9/10/16 indicated Resident 11 had a witnessed fall.

An Event Report from 11/1/16 noted Resident 11 had a witnessed fall in the hallway.

An Event Report from 1/21/17 noted Resident 11 was observed on the floor in her room.

An Event Report from 4/11/17 indicated Resident 11 had an assisted fall to the floor in her room. Resident 11 slid from the bed to the floor mat,

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F 279	Continued From page 9 and she was not injured as a result of the fall. The facility's 12/23/14 policy titled "Interdisciplinary Team/Care Plan Process" indicated, "Care plans are reviewed and revised as needed:...upon identification of a medical change in condition...when there has been a significant change in the resident's status during the weekly summary process...no less than quarterly." Resident 11 was observed in her bed on 5/15/17 at 11:45 a.m. The left side of the bed was placed against the wall. On the right side of the bed a one-third length bed-side rail was raised along the top third of the bed. The bed-side table was placed along the middle third of the bed and Resident's wheelchair was placed along the bottom third of the bed. A padded floor mat was pushed away from the right side of the bed. In an interview with Licensed Nurse 3 (LN 3) on 5/15/17 at 11:50 a.m., LN 3 observed the equipment up against Resident 11's bed and reported Resident 11 was at risk of experiencing a fall, and the padded mat that was pushed away from the side of the bed was supposed to be along the bed to protect Resident 11 in the event she fell from the bed. In an interview with Unit Manager 1 (UM 1) on 5/15/17 at 3:15 p.m., she reported a landing pad was expected to be used at Resident 11's bedside to minimize her risk of injury if she fell. She reviewed Resident 11's comprehensive plan of care and confirmed the landing pad was not identified as a specific intervention the staff were expected to employ to prevent injuries in the event of a fall. UM 1 reported the landing pad	F 279		

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F 279	Continued From page 10 should have been identified on the plan of care.	F 279		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to minimize the risk of injury for 1 of 19 sampled residents (Resident 11) when a staff member removed the protective landing pad from the side of Resident 11's bed. This failure increased Resident 11's risk of injury as a result of a potential fall from her bed.	F 323	**F 323** **Affected Resident:** The noted "landing pad" [fall mat] was correctly placed for resident 11. **Potentially Affected Resident:** All residents at risk for falls, and who are identified via the IDT process, as potentially benefiting from protective intervention(s) such as the placement of a "fall mat" are potentially affected by this POC. **Correction:** All residents at risk for falls will be reviewed by the Fall Prevention IDT for appropriate Care Plans to prevent injury inclusive of the placement of a fall mat. The facility's Medical Records department will audit, via the list of residents provided by the Fall Prevention IDT, once per week for a four week period commencing during the "completion period" noted on this POC. **Monitoring:** The facility's Fall Prevention IDT will present the findings of the above interventions and audits to the quarterly QAPI Patient Care committee for review and necessary follow up.	6/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 11 Findings: Resident 11 was admitted to the facility in 2012. Her diagnoses included history of falls. A 2/10/14 care plan for "Falls" indicated Resident 11 was at greater risk of experiencing a fall relating to her history of falling, dementia, and use of antipsychotic medications. An Event Report from 9/9/16 indicated Resident 11 fell in her room between the bed and her wheelchair. Resident 11 was sitting on the padded floor mat next to her bed and she was not injured as a result of the fall. An Event Report from 9/10/16 indicated Resident 11 had a witnessed fall. An Event Report from 11/1/16 noted Resident 11 had a witnessed fall in the hallway. An Event Report from 1/21/17 noted Resident 11 was observed on the floor in her room. An Event Report from 4/11/17 indicated Resident 11 had an assisted fall to the floor in her room. Resident 11 slid from the bed to the floor mat, and she was not injured as a result of the fall. Resident 11 was observed in her bed on 5/15/17 at 11:45 a.m.The left side of the bed was placed against the wall. On the right side of the bed a one-third length bed-side rail was raised along the top third of the bed. The bed-side table was placed along the middle third of the bed and Resident's wheelchair was placed along the bottom third of the bed. A padded floor mat was	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555083	A. BUILDING _____ B. WING _____	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 12 pushed away from the right side of the bed. In an interview with Certified Nursing Assistant 1 (CNA 1) on 5/15/17 at 11:45 a.m., she reported she placed the table and the wheelchair next to the bed because Resident 11 would try to get out of the bed without assistance if she left an "opening" along the side of the bed. In an interview with Licensed Nurse 3 (LN 3) on 5/15/17 at 11:50 a.m., LN 3 observed the equipment up against Resident 11's bed and reported Resident 11 was at risk of experiencing a fall, and the padded mat that was pushed away from the side of the bed was supposed to be along the bed to protect Resident 11 in the event she fell from the bed.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 329	**F 329** **Affected Resident:** Resident 11's Care Plan has been updated to accurately reflect the behaviors being monitored are consistent with the established need for the antipsychotic medication(s) recommended the attending psychiatrist and approved by the attending physician. **Potentially Affected Residents:** All residents receiving a antipsychotic medication are potentially affected by this POC. **Correction:** All licensed care staff will be inserviced regarding the monitoring/documentation requirements of behaviors of residents	6/18/17

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F 329	Continued From page 13 (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to protect 1 of 19 sampled residents (Resident 11) from the use of unnecessary drugs when an antipsychotic medication was administered without adequate indications for its use. This failure increased Resident 11's potential risk of significant side effects of the medication and falls. Findings: Resident 11 was admitted to the facility in 2012. The Face Sheet, (an informational page located at the beginning of the clinical record, listed her diagnoses which included dementia without behavioral disturbance, anxiety disorder, and Alzheimer's disease (a form of dementia). Bipolar disorder (A mood disorder) and psychosis	F 329	**F 329 Correction cont.:** receiving antipsychotics which must be consistent with the medication(s) ordered. Further, licensed staff members will be inserviced regarding the requirement to report to the attending physician an increase or decrease in behavior which may indicate the need to adjust the dosage of medication inclusive of the institution of a program of gradual dose reduction (GDR). The facility's Social Services department will review all residents receiving antipsychotics for consistency between the behavior being monitored and the diagnosis for the antipsychotic to be prescribed/administered. **Monitoring:** The facility's Unit Managers will review the above audits to confirm accuracy. The facility's Unit Managers will present these audits at the QAPI quarterly Pharmacy Committee meeting for review and potential follow up.	

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F 329	Continued From page 14 (a thought disorder) were not listed as diagnoses. The clinical record for Resident 11 included the following information: On 1/29/14 the physician ordered 4 milligrams (mgs, a dose measurement) of perphenazine, (an antipsychotic medication) to be given every evening to treat bipolar disorder with psychosis. The order indicated the psychosis manifested as "talking to self" and "fearful expression during care." The order for perphenazine included a "black box warning" (reasonable evidence of association with a serious effect due to diagnosis). There was no documented evidence in the clinical record the physician directed nursing staff to attempt a gradual dose reduction since the medication was ordered on 1/29/14. A 2/10/14 care plan for "Falls" indicated Resident 11 was at greater risk of experiencing a fall related to her use of antipsychotic medications. Behavioral data collected from January 2016 through March 2017 indicated Resident 11 experienced 6 episodes of "Fearful expression during care" during the 15 month period. Behavioral data collected from January 2016 through March 2017 indicated Resident 11 experienced 17 episodes of "talking to self." There was no specific description of the talking to self to indicate the behavior was distressing in any way to Resident 11. An Event Report from 9/9/16 indicated Resident 11 fell in her room between the bed and her wheelchair.	F 329		

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F 329	Continued From page 15 An Event Report from 9/10/16 indicated Resident 11 had a witnessed fall. An Event Report from 11/1/16 noted Resident 11 had a witnessed fall in the hallway. An Event Report from 1/21/17 noted Resident 11 was observed on the floor in her room. An Event Report from 4/11/17 indicated Resident 11 had an assisted fall to the floor in her room. On 5/5/17 the psychiatrist assessed Resident 11 and determined the resident benefited from the use of the antipsychotic medication because it was managing her hallucinations of seeing dead people. The psychiatrist noted Resident 11 was known to him and he last saw her 1/2014. He reported Resident 11 repeated the word "no...no" during the assessment, but there was no indication she reported seeing dead people to the psychiatrist. The psychiatrist recommended continuing the administration of the antipsychotic. There was no documented evidence Resident 11 was hallucinating dead people, or that these hallucinations were distressing to her, if she did. There was no documented evidence in Resident 11's clinical record the staff were monitoring her for hallucinations, which was the justification identified by the psychiatrist for continuing the antipsychotic medication in the 5/5/17 assessment . On 5/15/17 at 1:15 p.m., Resident 11 was observed as she self-propelled herself in her wheelchair as she returned to her room from lunch. Resident 11 had a flat affect and did not	F 329		

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F 329	Continued From page 16 respond verbally when addressed. On 5/16/17 at approximately 8:30 a.m., Resident 11 was observed in the hallway as she self-propelled her wheelchair back to her room. Resident 11 displayed a flat affect and did not speak to staff in attendance. In a concurrent interview with Certified Nursing Assistant 2 (CNA 2) on 5/16/17 at 8:30 a.m., she reported she provided care to Resident 11 and was very familiar with Resident 11's behaviors. CNA 2 reported Resident 11 no longer tried to leave the building, and was not resistive or fearful during care. She reported Resident 11 did not speak much, but communicated by holding hands and caressing. CNA 2 reported Resident 11 could be comforted by stroking her arm. In an interview with the Executive Director of Quality and Compliance (EDQC) on 5/17/17 at 1:45 p.m., she reviewed Resident 11's clinical record and verified there was no evidence Resident 11 was being monitored for the behavior the psychiatrist identified in the 5/5/17 assessment in which he established the need for an antipsychotic medication. Furthermore, the EDQC verified the behavior of "talking to self" was not sufficiently described to indicate it was a distressing symptom, and the behavior of being fearful during care was an infrequent behavior. The EDQC confirmed a gradual dose reduction had not been attempted since 1/29/14.	F 329		
F 388 SS=D	483.30(c)(3)(4) PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP (c) Frequency of Physician Visits	F 388	**F 388** **Affected Resident:** The attending physician for resident 11 has been made aware of the requirement to conduct a physician visit at a minimum of 60 day intervals.	6/18/17

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	555083	A. BUILDING _____ B. WING _____	05/18/2017

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F 388	Continued From page 17 (3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. (4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and and record review, the facility failed to ensure 1 of 19 sampled residents (Resident 11) was seen by her physician at least once every 60 days. This failure led to a reduction of physician supervision of Resident 11. Findings: Resident 11 was admitted to the facility in 2012. Resident 11's clinical record contained the following physician visit records: The physician visited Resident 11 on 5/20/16. The physician visited Resident 11 on 8/22/16. Two nurse practitioner visits occurred between the 5/20/16 and 8/22/16 physician visits. However there was a 90 day gap between the physician visits. The physician visited on 10/27/16, and again on 12/28/16. There were no nurse practitioner or physician assistant visits between these 2 physician visits. The facility's 4/18/08 policy titled "Physician visit	F 388	**F 388 Continued:** **Potentially Affected Residents:** All residents are potentially affected by this POC. **Correction:** As noted above the attending physician for resident 11 has been made aware of the visitation requirement. The facility's medical records department will conduct random monthly audits of physician visits to confirm compliance. These audits will continue for a period of three months for the purpose of review at the QAPI quarterly Patient Care committee meeting. These audits will remain ongoing as a regular practice of the facility beyond the three month review noted above. **Monitoring:** A summary report of the above audits will be submitted to the facility's QA Patient Care committee for review and any necessary follow up action.	

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F 388	Continued From page 18 schedule" indicated, "At the option of the physician, required visits, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner....If an alternative visitation schedule is utilized, the maximum days between physician visits shall not exceed 60 days." In an interview with Unit Manager 1 on 5/15/17 at 3:15 p.m., she reviewed Resident 11's chart and confirmed there was no documented evidence Resident 11 was seen by the physician at least once every 60 days, alternating with either the nurse practitioner or the physician assistants on alternate 30-day intervals.	F 388		
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure controlled medications were taken out of a medication cart in a timely manner for a census of 91. This failure increased the risk of medication errors.	F 425	**F 425** **Affected Resident:** As noted in the 2567 summary statement all residents identified have been discharged. **Potentially Affected Residents:** All residents receiving care inclusive of controlled medication administration are potentially affected by this POC. **Correction:** The controlled medications of the noted discharged patients represented in the "Blue" medication cart were removed. The facility's Unit Mangers inspected each of the remaining medication carts for the presence of controlled medications of patients who had been discharged.	6/18/17

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F 425	Continued From page 19 Findings: During the inspection of the blue medication cart, on 5/16/17 at 8:36 a.m., the following discharged resident's controlled medications were found on the medication cart: 1) Random Resident (RR) 20 was discharged from the facility on 4/10/17. There were 107 tablets of Norco (narcotic pain reliever) prescribed to the resident found in the medication cart. 2) RR 21 was discharged from the facility on 4/19/17. There were 26 tablets of Norco prescribed the resident found in the medication cart. 3) RR 22 was discharged from the facility on 4/14/17. There were 50 tablets of Tramadol (narcotic pain reliever) prescribed to the resident found in the medication cart. 4) RR 23 was discharged from the facility on 2/2/17. There was a 250 ml bottle of Codeine-Guaifen (cough suppressant and expectorant) prescribed to the resident found in the medication cart. 5) RR 24 was discharged from the facility on 4/13/17. There were 98 tablets of Roxicodone (narcotic pain reliever) prescribed to the resident found in the medication cart. 6) RR 25 was discharged from the facility on 3/30/17. There were 115 tablets of Norco and 20 tablets of Ativan (anti-anxiety) prescribed to the resident found in the medication cart.	F 425	**F 425 Correction cont.:** The facility's DON, Unit Managers, DSD or their designee will conduct inservices with licensed staff members regarding the requirement to remove controlled medications from the respective medication carts following the discharge of a patient. The facility has established a practice of scheduled removal of medications on designated days of each week to ensure "timely" removal of narcotics per Eskaton policy. **Monitoring:** A random, Q shift, medication cart inspection to confirm "timely" removal of narcotics will be conducted by the RN supervisor for 5 of 7 days, per week for a period of one month commencing within the "completion date" noted on this POC. The results of these inspections will be documented and reviewed at the QAPI quarterly Pharmaceutical meeting.	

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F 425	Continued From page 20 7) RR 26 was discharged from the facility on 2/13/17. There were 28.5 ml (milliliter, a dose measurement) left of Hydromorphone (narcotic pain reliever) prescribed to the resident found in the medication cart. 8) RR 27 was discharged from the facility on 1/20/17. There were 29 ml left of Lorazepam (anti-anxiety) and 17.75 ml left of a bottle of Morphine (narcotic pain reliever) prescribed to the resident found in the medication cart. 9) RR 28 was discharged from the facility on 4/29/17. There were 27.75 ml left of a bottle of Roxanol (narcotic pain reliever) prescribed to the resident found in the medication cart. Review of the facility's policy, "Disposal of Medications," dated 05/2016, indicated, "Discontinued medications and/or medications left in the nursing care center after resident's discharge, which do not qualify for return to the pharmacy, are identified and removed from current medication supply in a timely manner for disposition." In an interview with the Executive Director of Quality & Compliance, on 5/16/17 at 8:46 a.m., she confirmed the above findings. She stated when a resident is discharged from the facility the controlled medications are to be brought to the Director of Nursing's office to be logged and put the closet within 24 hours.	F 425		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441	**F 441** **Affected Residents:** As noted in the 2567 summary the CNA caring for resident #9 repositioned the urinary drainage bag so as to not contact the floor. The nebulizer masks for residents 30 and 31 have been correctly stored.	6/18/17

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F 441	Continued From page 21 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 441	**F 441 Continued:** **Potentially Affected Residents:** Residents using treatment devices subject to infection prevention protocol(s) are potentially affected by this POC. **Correction:** The facility's DSD, DON or their designee will conduct inservices with direct care staff regarding the proper protocol associated with the use of treatment and care equipment such as urinary drainage bags and nebulizer masks. **Monitoring:** A random, Q shift, inspection to confirm proper infection prevention protocol is maintained for items such as urinary drainage bags and nebulizer masks will be conducted by the RN supervisor or their designee for 5 of 7 days, per week, for a period of one month commencing within the "completion date" noted on this POC. A summary report will be submitted to the QA Infection Prevention Care committee at the quarterly meeting for review and possible follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 22 circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review; the facility failed to ensure infection control standards were maintained for one of 19 sampled residents (Resident 9) and two random residents (Random Resident 30 and Random Resident 31) when: 1. Resident 9's urinary drainage bag and dignity cover (a solid dark colored bag used to cover a urinary drainage bag) were observed touching the floor; and 2. Random Resident 30 and Resident 31's nebulizer masks (a device that fits over the mouth and nose used during delivery of inhaled respiratory treatments) were not stored in the	F 441		

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F 441	Continued From page 23 designated bags. These failures increased the potential to spread infection. Findings: 1. Resident 9 was readmitted to the facility on 4/23/17 with diagnoses of quadriplegia (total or partial inability to move all four extremities), and a urinary catheter and urinary tract infection. During the Initial Tour and observation, on 5/15/17 at approximately 8:50 a.m., the velcro strap that secured Resident 9's urinary drainage bag and privacy cover to the bed frame to prevent the bag from touching the floor was observed to be loosened with a very small area of Velcro holding the strap together. The urinary drainage bag and privacy cover were touching the floor. During an interview with Certified Nurse Assistant 3 (CNA 3), on 5/15/17 at approximately 8:50 a.m., she was observed tightening up the velcro strap with the urinary drainage bag and privacy cover simultaneously lifted and secured off the floor. CNA 3 relayed that the urinary drainage bag "should be up off the floor." The facility policy and procedure titled "Infection Control Program" revised 11/17/15 indicated, "The primary purpose of this community's Infection Control Program is to establish guidelines designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of disease and infections....the objectives of our Infection Control Program is to...maintain a safe, sanitary, and comfortable environment for...residents..."	F 441		

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ESKATON CARE CENTER MANZANITA	5318 MANZANITA AVENUE CARMICHAEL, CA 95608

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F 441	Continued From page 24 2. During the Initial Tour and observation, on 5/15/17 at approximately 7:45 a.m., Random Resident 31's nebulizer mask was observed uncovered and placed on the nebulizer machine (an apparatus used to produce a fine spray or mist typically used during the administration of inhaled respiratory medications) located on the resident's bedside dresser. During the Initial Tour and observation, on 5/15/17 at approximately 8:55 a.m., Random Resident 30's nebulizer mask was observed uncovered and placed on the nebulizer machine located on the resident's bedside dresser. During an interview with CNA 3 on 5/15/17 at 8:55 a.m., she stated, "the nurse should have put the mask in the bag." The facility policy and procedure titled "Nebulizer Equipment" revised 12/02/16, indicated "Nebulizers and tubing are to be changed...and reduce possible infection...after each use...store in clean bag between uses."	F 441		