STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056410	A. BUILDING _____ B. WING _____	C 01/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITNEY OAKS CARE CENTER ACCEPTED 2/19/14 CH	3529 WALNUT AVENUE CARMICHAEL, CA 95608

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during an abbreviated standard survey of entity reported number CA000384725. Representing the Department: HFEN 29825 The inspection was limited to the specific entity reported incident and does not represent a full inspection of the facility.	F 000		2-12-14
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	**PLAN OF CORRECTIONS** **"This plan of correction is prepared as part of the quality assurance process for the provider. This plan of correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such are protected from discovery."** **"This plan of correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes, and or guidelines. As this transmission is**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] Kaur | TITLE: RN | (X6) DATE: 2/14/14

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 278	Continued From page 1 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the clinical record, and facility policies and procedures, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the residents' status for 1 of 2 sampled residents (1). This failure had the potential risk of inappropriate treatment for Resident 1. Findings: Resident 1 was admitted 9/7/10 with diagnoses including altered mental status, dementia with behavioral disturbances and psychosis (seeing or hearing things that are not real). Her Minimum Data Set (MDS, an assessment tool), dated 10/30/13, indicated she had no signs or symptoms of delirium, no mood issues, behaviors or psychosis. During a concurrent observation and interview with Resident 1 on 1/23/14 at 2:02 p.m., she spoke in a word salad (putting words together that did not make a complete thought). She could not answer questions in a way that was understood. Resident 1's clinical record was reviewed: > The document titled Care Plan, dated 5/19/12,	F 278	**required by law, it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations."** **The Minimum Data Set (MDS) assessment for resident 1 was corrected on 1/27/14 to indicate resident current diagnosis, mood and behaviors.** **The MDS nurse along with the Social services director (SSD) reviewed all the MDS assessments for residents that have behaviors and or diagnosis of psychosis to ensure that they were coded correctly and they were revised as needed.** **The social services assistant (SSA) was re-educated by the SSD on properly coding the MDS.** **The SSD will review all the MDS's completed by the**	2-12-14

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F 278	Continued From page 2 described Resident 1's behaviors as "Extreme agitation M/B [manifested by] combativeness, striking out at others, scratching at others, throwing objects, swearing, screaming...refusing medication/care from nursing... MD and RP [responsible party] are aware" > The document titled Resident Progress Notes, dated 8/26/13, by MD 1, noted "... unreliable secondary to dementia." > The document titled Resident Progress Notes, dated 9/24/13, by MD 2, noted in the monthly evaluation "h/o [history of] dementia...Pt [patient] is non-compliant with meds..." > The document titled Resident Progress Notes, dated 10/15/13, by Nurse Practitioner 1 (NP 1) described Resident 1. "She is still refusing treatments and labs...alert but confused...resistive to care... [with] dementia." > The document titled Resident Progress Notes, dated 10/21/13 and completed by Licensed Nurse 1 (LN 1), documented "...resistive to care...frequently gets verbally aggressive with staff." > The document titled Resident Progress Notes, dated 10/28/13 and completed by LN 2, described Resident 1's behavior as "...verbally responsive with confusion...continues to refuse...patient care the majority of...shift, constantly refuse to go to bed...when have been in W/C [wheel chair] all day..." > The document titled Observation Report:...Weekly Summary", dated 10/28/13 established Resident 1 was "Confused at all	F 278	**SSA for the next 30 days and randomly thereafter, to ensure they are coded correctly.** **The MDS nurse will review the MDS for completion prior to closing the MDS.** **The MDS nurse and the SSD will report to the Director of Nursing with any issues noted.** **The Social Services Director will report any non compliance issues to the Quality Assurance Committee for recommendations as needed.**	2-12-14

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F 278	Continued From page 3 times". > The document titled Resident Progress Notes, dated 10/31/13, by Social Services Assistant indicated "Quarterly Assessment:...incapable of understanding rights...Cognitive:...Refused to answer ..." > The document titled Observation Report, dated 11/5/13, completed by LN 3 indicated Resident 1 was "disoriented X 3...CONTRIBUTING FACTORS [to falls]....Psychiatric Or Cognitive - Delirium; Decline in cognitive skills; manic depression; Alzheimer's Disease; Other Dementia..." > The document titled Resident Progress Notes, dated 1/20/14, by NP 1 continued to describe Resident 1 as "Patient is so resistive to to care and has dementia that she will not allow a proper exam and she is unable to say what happen...alert but confused...Altered mental status, Dementia..." During an interview with LN 4 on 1/23/14 at 2:11 p.m., she described Resident 1 as "confused, sometimes combative, non-compliant..." During an interview with CNA 1 on 1/23/14 at 2:25 p.m., she said "She's confused and non-cooperative. She told me to get my fat [expletive] out of the way. During an interview with CNA 2 on 1/23/14 at 3:25 p.m., she described Resident 1 "When you change her, she fights and scratches...When she's mad she'll thrash, hit me. She has accidentally hit herself before."	F 278		

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F 278	Continued From page 4 During a concurrent record review and interview with Social Services Assistant 1 (SSA 1) on 1/24/14 at 9:15 a.m., she verified the MDS was incomplete and not filled out accurately: > "Section C Cognitive Patterns, C0600" had been left blank. "It's supposed to be done [completed]. "Delirium section C1300", indicated behavior was not present for "A. Inattention and B. Disorganized thinking". SSA 1 said, "I may have made a mistake." > "Section D Mood, D0500", the Staff Assessment of Resident Mood, was blank. > "Section E Behavior, E0200" indicated Resident 1 had no indicators of psychosis and no "A. Physical behavioral symptoms directed toward others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually) B. Verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others, cursing at others)." A facility policy and procedure for filling out the MDS was requested on 1/24/14 but not provided.	F 278		