STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056212	A. BUILDING _____ B. WING _____	C 01/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW GLEN CENTER	1267 MERIDIAN AVENUE SAN JOSE, CA 95125

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a standard abbreviated survey regarding investigation of an entity reported incident conducted on 12/1/16, 12/13/16, 12/14/16, 12/15/16, 12/16/16, and 1/3/17. For Entity Reported Incident CA00511304 regarding Quality of Care/Treatment, a federal deficiency was identified (see F323) and a Class "B" Citation was also identified. 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 California Department of Public Health: 35158, Health Facilities Evaluator Nurse.	F 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH JAN 12 2017 L & C DIVISION SAN JOSE	
F 323 SS=G	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.	F 323	Next Page	

LABORAT[redacted]IER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 1-11-17

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 323	Continued From page 1 (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 interview and record review, the facility failed to ensure the resident's environment remained as free from accident hazards and received adequate supervision and assistance devices to prevent a fall for one of three sampled residents (Resident 1). On 11/17/16, Resident 1 used a walker, which was placed at his bedside, to go to the bathroom. It was uncertain who provided to the walker to the resident. Without assistance, using the walker, Resident 1 walked to the bathroom, had an unwitnessed fall, and sustained an L1 (the first lumbar vertebra (lower back)) fracture (a complete or partial break in a bone). This failure resulted in Resident 1 sustaining a fall and injury. Findings: Review of Resident 1's clinical record indicated he was admitted to the facility on 11/14/16 with diagnoses of dyspnea (difficult or labored breathing), pain in unspecified joint, difficulty in walking, generalized muscle weakness, and back pain. Review of Resident 1's Functional Abilities and Goals Assessment dated 11/14/16 through	F 323	F323-483.25(d)(1)(2)(n)(1)-(3) Corrective Action: Resident 1 discharged from the facility so there is nothing we can do to help him at this point. Other Residents: By 1-10-17 nursing will ensure that all other residents who are doing rehab will be checked to ensure that they are safe ambulating in their rooms. If they are not safe to ambulate in their rooms they will be instructed by nursing or rehab on what they can and can not do from an ambulation standpoint and what equipment they should use. Systemic Changes: By 1/9/17 the DON or Rehab Director will in-service rehab staff to inform residents doing rehab if they can or can not ambulate in their rooms. Rehab staff will also be in-serviced to inform nursing what ambulation restrictions each rehab resident has. Monitoring: The Rehab Director and DON will manage and monitor this process and the DON will bring it to QAA for review and follow up as needed.	1/10/2017

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F 323	Continued From page 2 11/16/16, indicated the resident required partial or moderate assistance with toilet transfer. Review of Resident 1's nurses notes dated 11/15/16, indicated the resident was alert, oriented, and able to make his own decisions. Review of Resident 1's physical therapy (PT) care plan dated 11/15/16 indicated the resident had functional deficits which included a decrease in bed mobility, transfers, gait, sitting balance, standing balance, and lower extremity strength and endurance. Review of Resident 1's occupational therapy (OT) care plan dated 11/15/16 indicated the resident required assistance with activities of daily living (ADLs) and mobility. Review of Resident 1's PT evaluation and plan of treatment dated 11/15/16 indicated the resident was referred to PT for the new onset of the decrease in functional mobility and pain. Resident 1 presented with an impairment of left lower extremity weakness due to pain and spinal stenosis (narrowing of the spinal canal). This impairment limited bed mobility, transfers, gait, and activity tolerance. Review of Resident 1's ADLs Documentation Survey Report dated 11/15/16 through 11/17/16, indicated the resident required limited to total assistance with the support of one person for toilet use. Review of Resident 1's nurse notes dated 11/17/16 at 7:23 a.m., indicated the resident had an unwitnessed fall on 11/17/16 at 2:40 a.m. after using the bathroom. Resident 1 stated when he	F 323		

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F 323	Continued From page 3 fell he had a crack on his back. Resident 1 was then transferred to an acute care hospital. Review of Resident 1's computerized tomography (CT, an imaging test of the inside of the body) spine lumbar (lower part of the spine) report dated 11/17/16 at 3:54 a.m., indicated the resident sustained an L1 fracture. Review of Resident 1's Post Fall Assessment dated 11/17/16, indicated the resident had an unsteady gait and used assistive devices (a device which helps people overcome a handicap such as mobility) such as a walker and a cane. He was also compliant with instructions to call for help when necessary. Review of Resident 1's interdisciplinary team (IDT) review dated 11/17/16, indicated the resident stated he went to the bathroom using his forward wheel walker (FWW). After using the toilet, Resident 1 stated he lost his balance and fell when he tried to back out of the bathroom. Resident 1 sustained an L1 fracture as a result of the fall. Review of Resident 1's PT daily treatment note dated 11/17/16, indicated the resident had a fall risk and was ambulating to the bathroom at the time of the fall using his personal walker. It indicated Resident 1 was not cleared for ambulation in the room. During an interview with Resident 1 on 12/1/16 at 11:45 a.m., he stated he went to the bathroom using his walker and when he started to leave, he fell on his back and heard a crack. Resident 1 stated he usually went to the bathroom by himself. He stated the facility did not tell him to	F 323		

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F 323	Continued From page 4 ask for assistance when he went to the bathroom. During an interview with the occupational therapist B (OT B) on 12/1/16 at 12:11 p.m., he stated Resident 1 complained of sciatic nerve pain. OT B stated Resident 1's balance was poor and based on the therapy department's evaluation, he could not go to the bathroom by himself. During an interview with physical therapist A (PT A) on 12/13/16 at 9:28 a.m., he stated during the initial evaluation, Resident 1 was in a lot of pain. PT A stated he did not want Resident 1 to walk. During an interview with PT A on 12/13/16 at 1:33 p.m., he stated Resident 1 did not have clearance from the therapy department whether he was able to walk in the room at the time of the fall. PT A stated nursing staff did not ask him whether it was safe for Resident 1 to walk in the room using his walker. During an interview with OT B on 12/13/16 at 1:37 p.m., he stated Resident 1 was at a fall risk. He stated the therapy department provided Resident 1 a wheelchair, but not the walker. OT B stated at the time of the fall Resident 1 was not fit to use a walker, and he was unaware who provided Resident 1 the walker. OT B also stated the nursing staff did not ask him whether Resident 1 was cleared to walk in his room using a walker. During an interview with licensed vocational nurse D (LVN D) on 12/13/16 at 2:23 p.m., she stated at the time of the fall Resident 1 had a walker and a cane in the room. LVN D stated she was unaware where the cane and walker came from.	F 323		

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F 323	Continued From page 5 During an interview with LVN C on 12/13/16 at 2:28 p.m., he stated he did not remember if Resident 1 brought a cane or a walker when he was admitted to the facility. During an interview with certified nursing assistant E (CNA E) on 12/14/16 at 8:51 a.m., he stated Resident 1 had a walker in the room. CNA E stated he always made sure the walker was at Resident 1's bedside. During an interview with CNA F on 12/14/16 at 9:20 a.m., she stated Resident 1 had a walker in his room before the fall incident. CNA F stated she had helped Resident 1 to go to the bathroom using a walker. During an interview with PT A on 12/14/16 at 12:58 p.m., he stated on 11/16/16 which was a day before the fall, Resident 1 had pre-gait training which was training to sit and stand to prepare for walking. PT A stated Resident 1's actual gait training occurred after the 11/17/16 fall and the resident started walking on 11/18/16. He stated the therapy department did not provide the walker which Resident 1 used at the time of the fall on 11/17/16. During an interview with CNA E on 12/16/16 at 11:10 a.m., he stated he was not informed Resident 1 was not allowed to use a walker in his room prior to the fall. During an interview with CNA H on 12/16/16 at 11:30 a.m., she stated no one informed her Resident 1 was not supposed to use a walker in his room. During a telephone interview with Resident 1 on	F 323		

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F 323	Continued From page 6 12/16/16 at 11:50 a.m., he stated no one in the facility informed him it was unsafe to use his walker in the room. He also stated he used the walker when he needed to go to the bathroom. Resident 1 stated he would not have used his walker if a staff member told him it was unsafe to do so. Review of the facility 10/13/06 policy "SUPERVISION OF RESIDENT CARE" indicated to assure that the resident's safety and well-being are maintained, the environment of the resident should be reviewed and checked for safety. All residents shall receive adequate supervision. The licensed nurse shall assure that care is implemented per the resident's individualized care plan.	F 323		