

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

POC accepted
6/17/14

PRINTED: 06/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER SAN JOSE HEALTHCARE & WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 75 N. 13TH STREET SAN JOSE, CA 95112		
(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 survey regarding investigation of entity reported incidents, conducted on 6/2/14. For Entity Reported Incident CA00398848 regarding Quality of Care, one Federal deficiency was identified (see F281). For Entity Reported Incident CA00398881 regarding Physical Environment, no State or Federal deficiencies were identified. Representing the California Department of Public Health: 32892, Health Facilities Evaluator Nurse.	F 000	San Jose Healthcare & Wellness Center submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employee, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow physician order for one of two residents (1) when the frequency of Ultram (Tramadol, opioid analgesic) was changed from every 8 hours to bedtime for pain management. The facility also failed to administer the appropriate pain medication based on level or severity of pain when the physician's telephone order was not clarified. This practice has the potential for medication error and under treatment of pain. Findings: 1. During review of Resident 1's clinical record, it	F 281	F281 483.20(k)(3)(i) Services Provided Meet Professional Standards What corrective action will be accomplished for those residents found to have been affected by the same deficient practice: Resident 1's June 2014 recap discrepancy for Ultram was corrected by the Licensed Nurse on 6/2/14.	6/2/14	

CALIFORNIA DEPARTMENT
OF PUBLIC HEALTH
JUN 17 2014
L & C DIVISION
SAN JOSE

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.

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

PRINTED: 06/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER SAN JOSE HEALTHCARE & WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 75 N. 13TH STREET SAN JOSE, CA 95112		
(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 281	<p>Continued From page 1</p> <p>indicated he fell on 5/14/16 and had been complaining of right rib pain. He was written a prescription for acetaminophen 650 mg (milligrams, a unit of measurement) every 4 hours for mild pain prior to fall. The physician order dated 5/11/13 indicated to assess level of pain using a pain scale of 0-10.</p> <p>0 = No Pain 1-3 = Mild Pain 4-7 = Moderate Pain 8-10 = Severe Pain</p> <p>Resident 1 continuously complained of right rib pain so his physician was contacted on 5/16/14. The physician ordered an X-ray which revealed questionable subacute fracture lateral right 7th rib. Physician also ordered Ultram, a stronger pain reliever, 50 mg every 8 hours for pain. There was no evidence the order was clarified to determine on what level of pain the medication should be given.</p> <p>The Pain Assessment Flow Sheet (a tool that tracks pain) for May 2014 indicated Resident 1 complained of moderate right rib pain on multiple occasions during May 16 to May 29, 2014. Ultram was only given once out of eleven occasions when Resident 1's level of pain was moderate.</p> <p>During an interview and record review with licensed nurse A (LNA) on 6/2/14 at 11:25 a.m., she stated that Ultram should have been given every time Resident 1 complained of moderate to severe pain or when the pain scale is over 4 (scale of 0-10). She further stated the physician should have been contacted in order to clarify the Ultram order and specify its indication as to what level or severity of pain it should be administered.</p>	F 281	<p>Resident 1's Ultram 50mg every 8 hours for pain order was clarified with the physician by the Licensed Nurse (LN) to determine on what level of pain the medication should be given on 6/2/14.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice: The Administrator ran a report showing all residents that are currently receiving Ultram. The Administrator audited the records of the 1 resident and found that there were no discrepancies on 6/16/14.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The recap nurse was in-serviced by the Director of Nurses regarding recapping of orders and the pain level range of a resident on multiple pain medications on 6/4/14.</p> <p>The Licensed Nurses were in-serviced by the Director of Nurses regarding the facility's "Telephone Orders for Medication" Policy on 6/11/14.</p>	6/2/14 6/16/14 6/4/14 6/11/14	

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

PRINTED: 06/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER SAN JOSE HEALTHCARE & WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 75 N. 13TH STREET SAN JOSE, CA 95112		
(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 281	<p>Continued From page 2</p> <p>Lexicomp Online (a nationally recognized drug literature website) indicated Ultram was indicated for moderate to severe pain. According to the 2001 World Health Organization (WHO) pain guidelines, analgesics should be individualized and available for different levels and severity of pain.</p> <p>A review of the facility's policy and procedure, 01/2012 "Pain Management," indicated a licensed nurse is responsible to ensure accurate assessment and management of the resident's pain. Nursing staff would implement timely interventions to reduce the increase in severity of pain."</p> <p>2. Further interview and record review with LN A was done on 6/2/14 at 1:15 p.m. A physician order, dated 5/16/14, indicated to give Ultram 50 mg every 8 hours for pain. However, the June 2014 MAR (Medication Administration Record) and June 2014 physician order indicated to administer Ultram 50 mg PO QHS (by mouth at hour of sleep), which is different from the original telephone order. She stated there could have been an error during the recapping (a process where licensed nurses review physician order for accuracy of current treatment and medication orders). LN A validated the error and stated she would fix the discrepancy on the physician order and the MAR as well.</p> <p>During an interview with the director of nursing (DON) at 2:10 p.m. on the same date, she stated that licensed nurses should have verified the accuracy and completeness of medication and treatment order during the recapping.</p>	F 281	<p>How the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>The Director of Medical Records will audit all new Ultram orders to ensure that the necessary information is included in the medication order to facilitate accurate delivery of medications to all residents. Any discrepancies will be reported to the Director of Nurses and Administrator.</p> <p>The Administrator shall provide a quarterly report to the Quality Assurance Committee for review and/or corrective action.</p>	<p>6/16/14 BVR</p>	

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

PRINTED: 06/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER SAN JOSE HEALTHCARE & WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 75 N. 13TH STREET SAN JOSE, CA 95112		
(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 281	Continued From page 3 A review of the facility's 01/2012 "Telephone Orders for Medication" indicated licensed nurses should ensure that the necessary information is included in the medication order to facilitate accurate delivery of medications and treatments to all residents.	F 281	Blank		

CALIFORNIA DEPARTMENT
OF PUBLIC HEALTH
JUN 17 2014
L & C DIVISION
SAN JOSE