STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI [redacted]	(X3) DATE SURVEY COMPLETED
	055240	A. BUILDING _____ B. WING _____	C 10/25/2012

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VILLA WATSONVILLE EAST NURSING CENTER	535 AUTO CENTER DRIVE WATSONVILLE, CA 95076

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	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH DEC - 6 2012 L & C DIVISION SAN JOSE		CALIFORNIA DEPARTMENT OF PUBLIC HEALTH L & C DIVISION SAN JOSE	
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey regarding complaint, CA00330574 conducted on 10/25/12. For Complaint CA00330574 regarding Quality of Care and Treatment, a Federal deficiency was identified (see F329). Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health was 25076, Health Facilities Evaluator Nurse.	F 000	**Country Villa Watsonville East Nursing 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 of its employees, agents, officer's 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 interest of the governmental agencies or third party for evaluation and appropriate treatment modalities.**	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	F329 Drug regimen is free from unnecessary drugs The Medical Director was notified that resident 1 medication regimen review recommendations were not being followed up by the residents Primary Care Physician. On 10/25/12	10/25/12

LABORATO[redacted]	TATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator		12/5/12

Any deficie[redacted]eficiency which the institution may be excused from correcting providing it is determined that other safeg[redacted]ee 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 329	Continued From page 1 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 ensure two of three sampled residents (1 and 2) were free from unnecessary drugs when pharmacy recommendations for medications which could increase the chances of a fall were not addressed by the resident's physician. Findings: 1. Resident 1 was admitted to the facility with diagnoses including muscle weakness and peripheral neuropathy (lack of nerve communication to and from the brain and extremities). The Minimum Data Set (MDS, an assessment tool) dated 9/24/12 indicated Resident in was independent in cognitive skills for daily decision making, she was noncompliant asking for assistance to transfer, was noncompliant with the use of a tab alarm for bed and wheelchair and had unwitnessed falls in August, September and October. (A tab alarm is an alarm that attaches to a person and activates when the person attempts to rise out of their chair). The clinical record for Resident 1 was reviewed on 10/25/12. The physician's order dated 1/31/09 indicated gabapentin (a medication used for neuropathic pain) 400 milligrams (mg) by mouth	F 329	The Medical Director reviewed the residents chart and spoke with the residents Primary Care Physician (PCP) regarding the medication regimen reviews recommendations. The residents PCP responded to the pharmacy recommendation on 10/29/12 to continue with the resident's current medication of Diazepam because the benefits outweighed the risks. The resident is also taking Neurontin 400mg BID and this medication was ordered to be titrated and then discontinued. This order received on 10/25/12. Resident 2 PCP responded to the pharmacy's recommendation on 10/29/12 regarding the resident's medication Aricept. The physician made no changes in the resident's medication due to the benefits outweighed the risks. All residents have the potential to be affected by this deficient practice. The Medical Records Director (MRD) will conduct an audit of all residents to ensure no further deficient practice has occurred. This audit was completed on 11/27/12. The MRD will continue this audit for one quarter. After the quarter is complete the MRD will bring the findings to	10/29/12 10/25/12 10/29/12 11/27/12

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F 329	Continued From page 2 (po) three times daily. The physician's order dated 3/19/09 indicated morphine sulfate (MS Contin) 360 mg every eight hours for pain management. The physician's order dated 3/30/10 indicated diazepam (an antianxiety medication) 10 mg po three times daily. The Medication Regimen Review (MRR) dated 7/9/12 indicated "Resident concurrent therapies of morphine and diazepam (used to treat anxiety, central nervous system depressant (CNS)) may contribute to change of condition and falls. If a CNS depressant is needed to be used concurrently with morphine, a reduced dosage of morphine and/or the CNS depressant may be needed based on clinical response." The MRR recommendation was faxed to the physician on 7/10/12, 7/12/12, 7/13/12 and 7/16/12 with no response from the physician. The MRR dated 9/6/12 indicated "Resident's routine diazepam therapy may sometimes contribute to change of condition. Most of the adverse effects associated with diazepam therapy are CNS-elated and dose-dependent including: drowsiness, dizziness, lightheadedness, syncope (fainting) and vertigo (feeling things around you are moving when they are not). Monitor and evaluate if possible effects correlate with falls, change of condition." The MRR was faxed to the physician on 9/7/12 and re-faxed again on 10/19/12. There was no documented response from the physician and Resident 1 continued on the diazepam routine therapy. The MRR dated 9/19/12 indicated "Resident's morphine therapy may contribute to change of	F 329	the CQI panel to decide if the audit shall continue. All licensed nursing staff has been in-serviced by the Director of Staff Development. The in-service entailed notifying the physician on any pharmacy recommendations they receive in a timely manor to prevent any occurrence of unnecessary drugs. This in-service was completed on 10/29/12. The Pharmacy Consultant will routinely conduct a monthly review of all residents to ensure all residents will be free from unnecessary drugs. The Pain and Behavior Management Committee ran by the Interdisciplinary Team will review the pharmacy recommendation on a quarterly basis and complete a summary trend analysis of the findings. These findings will be given to the Director of Nursing who will report to the quarterly CQI Committee for further review and recommendations.	change by Admin (DON) / Director of Nurses 10/29/12

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condition. Adverse reactions may include orthostatic hypotension (low blood pressure when standing) and syncope." The MRR was faxed to the physician on 9/20/12 and 10/19/12.

The MRR dated 9/28/12 indicated "Resident's gabapentin therapy may sometimes contribute to change of condition. Possible CNS adverse reactions associated with this treatment include somnolence (drowsiness), dizziness and abnormal co-ordination."

The MRR dated 10/22/12 indicated "Resident's routine diazepam therapy may sometimes contribute to change of condition and falls. Monitor and evaluate if possible effects correlate with change of condition." The MRR was faxed to the physician on 10/23/12.

During an interview and record review with licensed nurse A (LN A) on 10/25/12 at 10:45 a.m., she stated the policy of the facility was to fax the MRR to the physician and fax again if necessary when there were recommendations made by the pharmacist. She stated Resident 1's physician received all of the recommendations and would address all medications before making changes. She stated when staff contacted the office the receptionist was the person who received the call to the facility. She stated Resident 1 did not want to report any falls to the physician because she did not want her medications discontinued. She stated attempts made to contact the physician by phone or FAX should be documented in the nurse's notes. She stated she could not find documentation indicating staff notified the physician concerning the recommendations other than the faxes.

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During an interview with Resident 1 on 10/25/12 at 1 p.m., she stated she did not tell staff about many of her falls because the physician would make changes in her medications. She stated her physician called her and discussed her treatments and medications and she let him know if her medications were working or not. Resident 1 was falling asleep during the interview.

2. Resident 2 was admitted to the facility with diagnoses including dementia. The MDS dated 7/11/12 indicated Resident 2 was severely impaired in cognitive skills for daily decision making and had five falls during the month of August 2012.

The clinical record for Resident 2 was reviewed on 10/25/12. The medication regimen review (MRR [medication used to treat dementia]) dated 9/25/12 indicated "Resident's Aricept therapy may sometimes contribute to changes in condition. Potential adverse reactions associated with this therapy include asthenia (loss or lack of bodily strength, weakness), bradycardia (low heart rate), dizziness, drowsiness and syncope. The review indicated it was done for increase in falls. The MRR was faxed to the physician on 9/27/12." There was no indication of a follow up by the facility or response from the physician.

During an interview with the consultant pharmacist (CP) on 10/25/12 at 12:05 p.m., she stated the Aricept had adverse reactions which could lead to falls for Resident 2. She stated she posted the MRRs to alert the physician to the adverse reactions and she wanted a risks versus benefits analysis from the physician. She stated

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F 329	Continued From page 5 she had recently been to the facility and had done her reviews of the resident's medications for the month of October. She stated she would review the Aricept for Resident 2 again in November. For Resident 1 she stated because the resident had fallen several times she wanted a risks versus analysis benefits for the use of the diazepam from the resident's physician indicating continued use of the medication. She stated it was very hard to communicate with Resident 1's physician according to the nursing staff at the facility. She stated she continued to review Resident 1's medication monthly and continued to leave recommendations concerning the risks versus benefits analysis for the resident's medications. The facility policy and procedure titled "Consultant Pharmacist Reports" dated April 2008, indicated: Recommendations were acted upon and documented by the facility staff and or the prescriber. If there was a potential for serious harm and the attending physician did not concur, or the attending physician refused to document an explanation for disagreeing, the director of nurses or designee contacted the medical director. 1. During an interview with the DON on 10/25/12 at 12:30 p.m., she stated staff made many attempts to discuss the recommendations from the CP with Resident 1's physician, but he phoned the resident and spoke to her instead of calling staff to discuss Resident 1's medications and recommendations made by the CP. She stated her next step should be to involve the medical director, but she had not done so at this time.	F 329		