11/27/12 POC accepted 2nd submission Orig to follow

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

PRINTED: 11/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055311	A. BUILDING _____ B. WING _____	C 10/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KATHERINE HEALTHCARE	316 ALAMEDA AVENUE SALINAS, CA 93901

(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 standard survey regarding two entity reported incidents conducted on 10/26/12. Entity Reported Incident CA00330358 regarding Quality of Care/Treatment was not substantiated. Entity Reported Incident CA00330306 regarding Quality of Care/Treatment was substantiated and a Federal deficiency was identified (see F241). 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 Department of Health Services: 10918, Health Facilities Evaluator Nurse.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident's right to receive care in a respectful manner for one of two sampled residents (1). Resident 1's eyebrows were partially shaved by an unknown person. The incident was distressing to the resident's family. Findings:	F 241	Dignity and Respect of Individuality Residents affected: Resident 1 re-interviewed by the DON and indicated no psychological nor physical harm was sustained from incident. How to identify other residents having potential to be affected and corrective action taken: Facility rounds were done by DON and ED and no other residents were identified to	

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
NOV 27 2012
L & C DIVISION
SAN JOSE

LABORATORY DIRECTOR'S [redacted] TITLE (X6) DATE 11/26/12

Any deficiency statement [illegible] 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 241	Continued From page 1 Resident 1's record was reviewed on 10/26/12. The Minimum Data Set (MDS, an assessment tool) dated 8/15/12 indicated Resident 1 had short and long term memory problems and moderate difficulty in daily decision making skills. During an observation on 10/26/12 at 8:30 a.m. with the administrator (ADM), approximately half the length of Resident 1's eyebrows were without hair. The ADM stated Resident 1's eyebrows "looked shaven." Resident 1 offered no comment on what happened. In an interview on 10/25/12 at 10:45 a.m., the director of nurses (DON) stated the following. On 10/20/12, Resident 1's responsible party (RP 1) spoke to her regarding the family's observations that Resident 1's eyebrows had been shaven. A dark eyebrow liner (make-up) was applied over the length of both eyebrows. The DON interviewed staff members and found no witness, or any staff member who admitted to shaving the resident's eyebrows. The DON stated it was likely done by a certified nurse assistant assigned to provide care to the resident. The DON also stated there was no facility policy and procedure regarding staff shaving residents. During an interview on 10/26/12 at 10:45 a.m., a licensed nurse (LN A) recalled Resident 1's family members were "upset" about the shaven eyebrows. LN A stated staff were not allowed to shave without asking permission from the resident or family. In an interview on 10/25/12 at 1:40 p.m., RP 1 stated the family was upset and thought it was	F 241	have had their eyebrows shaved. Random resident checks will be conducted by all managers by utilizing the QA tool and Findings will be reviewed daily at stand up meeting. findings of QA audit will be discussed in quarterly Meetings for 2 quarters. Systemic changes: The CNA staff member who was identified As assigned to resident's care during the incident was placed on administrative leave for the period of investigation of four days, from 10/22-10/26/12. The CNA received disciplinary action to include suspension and probation with recommendation for termination if further issues arise. The DSD provided an all shifts CNA in-service on 10/25/12 & 10/26/12 on Dignity and Respect of Individuality. This in-service will be provided quarterly as a prevention measure.	10/26/12 & ongoing 10/26/12 & ongoing

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F 241	Continued From page 2 dangerous, "they could have cut" [Resident 1]. No one asked permission to shave the resident, and if they had, RP 1 "would have said no."	F 241		