STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030001534	A. BUILDING _____ B. WING _____	C 12/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND SKILLED NURSING FACILITY	678 THIRD STREET WOODLAND, CA 95695

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of complaint number CA00291530. Representing the Department of Public Health: HFEN, 1948/29823 The inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full investigation of the facility.	A 000	1) Pt 1 is no longer here. She lived at this facility for at least 2 years and had received great compassionate care. 2) Pt 1 was sent to the hospital because her family wanted her to be sent. Her family: sister and niece live in Oregon and they rarely visited. 3) Our record show that when pt 1 asked for a pain pill she received one and when she asked for a muscle relaxant she received that too. 4) All nurses were in-service on completing accurate times and names of MDs and RP notification of changes. 5) All nurses were also in serviced on documenting actual times of any new changes in the medical record regardless of when they arrive at charting. A 396) All nurses were in serviced on checking and rechecking their narcotic for expiry dates. 7) All nurses were in serviced on the proper way of obtaining/ordering medication from pharmacy	12/24/11 1/24/11 12/24/12
A 174	T22 DIV5 CH3 ART3-72311(a)(3)(G) Nursing Service--General (a) Nursing service shall include, but not be limited to, the following: (3) Notifying the attending physician promptly of: (G) The facility's inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies or services as prescribed under conditions which present a risk to the health, safety or security of the patient. This Statute is not met as evidenced by: Based on interview and record review, the facility failed notify the attending physician of the inability to obtain or administer an as needed pain medication to Patient 1 when it was ordered for her. Findings: Patient 1 was a 58 year old, admitted to the facility on 9/30/09 with diagnoses including cerebral palsy (non-contagious and non-progressive motor problems that cause physical disability especially in the areas of body movement) and muscle spasm (spasticity).	A 174		

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A 174	Continued From page 1 Physician's Orders stipulated Patient 1 had mental capacity to make his/her own decisions. In an interview with Patient 1 on 12/13/11 at 9:10 a.m., she said she had fallen at approximately 9 a.m. on Friday, 11/25/11. She told the nurse (licensed vocational nurse 1) she had a lot of pain in her left knee. Review of Patient 1's Physician Orders indicated an order dated 9/30/11 for Norco 10/325 1 tab by mouth every four hours as needed for moderate pain and Norco 10/325 2 tabs by mouth every four hours as needed for severe pain. In an interview with licensed vocational nurse 1 (LVN 1) on 12/13/11 at 2:10 p.m., she said on 11/25/11, she was checking to see if there was adequate Norco 10/325 in the medication cart for Patient 1 "in case" she needed it for pain due to a fall that same day. There was none in the medication cart. LVN 1 said she ordered some from the pharmacy on 11/25/11 and it was not delivered on 11/25/11, 11/26/11, 11/27/11 or 11/28/11. In an interview with the Director of Nursing on 12/13/11 at 2:15 p.m. she acknowledged LVN 1 should have called the Director of Nursing, Physician, Medical Director or the "back-up" Medical Director of not receiving a drug at the facility when it was ordered. In an interview with LVN 1 on 12/13/11 at 3 p.m., with LVN 1, she acknowledged she did not notify Patient 1's physician of the inability to get delivery of Norco 10/325 from the pharmacy. In an interview with the Director of Nursing on 12/14/11 at 4:20 p.m., she said, "Nurses should	A 174	and the chain of commands that needs to be followed when medications are not available. A 394 8) Our med locker contains 96 different medications in it and it is fairly easy to access and obtain meds per MD orders. A 394 9) Our policy states that Narcotics can be discontinued if they were not used in 60 days: This is part of reevaluating residents' care and needs. 10) Pt 2's had been living here for about a year. A 82r 11) Pt's conservator is very grateful for pt 2's care and is very happy about her placement with us. This facility had and still does accept challenging patients and residents that no other facility in the community will or able to administer the care level. This facility is delighted to be a great contributor to this community. A 394 12) The pharmacy will continue to audit our carts quarterly and as needed to identify any missed expiration meds.	12/24/11 12/24/11 12/24/11

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A 174	Continued From page 2 have called the pharmacy after missed deliver of Norco the next morning [11/26/11]."	A 174	A-82213) The medical record department will continue to audit for change of condition, complete documentations and relay instructions to staff as appropriate. 14) The DON will continue with spot audits on both carts and records for relevant issues. 15) The Administrator is responsible to oversee medical records audits completed timely. 16) Any issues that continue to be outstanding on this regards will be brought to QA. 17) Since the complaint investigation was conducted: we had 100% timely reporting to MD and RP with 100% documentations of actual times and relevant parties. 18) Since the investigation was conducted, we had medication carts with 100% non expired meds. We will continue to administer compassionate care and are committed to 5 star rating.	4/18/12 4/18/12
A 179	T22 DIV5 CH3 ART3-72313(a)(2) Nursing Service--Administration of Medication (a) Medications and treatments shall be administered as follows: (2) Medications and treatments shall be administered as prescribed. This Statute is not met as evidenced by: Based on interview and record review, the facility to failed to follow physician's orders for "as needed" pain medication administration when Patient 1 complained of pain in her left knee and was not given the pain medication as ordered by the physician. Findings: Record review of Patient 1's nurses notes dated 11/25/11 a.m. indicated, "...Did c/o pain to knee and femur on left side." Review of Patient 1's Physician Orders indicated an order dated 9/30/11 for Tylenol 325 milligrams (mg), 2 tabs by mouth every 6 hours as needed for mild pain, and Norco 10/325 1 tab by mouth every four hours as needed for moderate pain and Norco 10/325 2 tabs by mouth every four hours as needed for severe pain.	A 179		

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A 179	Continued From page 3 Review of Patient 1's Medication Record for 11/1/11-11/30/11 indicated no Tylenol or Norco were documented as administered on 11/25/11 or 11/26/11. In an interview with complainant on 12/12/11 at 1:45 p.m., he said Patient 1 alleged she had fallen and had been given Robaxin (a muscle relaxant) after the fall, but it did no good. According to the complainant, Patient 1 alleged she had a Norco order, but it was an "as needed medication" and, because it had not been given for 60 days, it had expired. In an interview with Patient 1 on 12/13/11 at 9:10 a.m., she said she had fallen at approximately 9 a.m. on Friday, 11/25/11. She told the nurse (licensed vocational nurse 1) she had a lot of pain in her left knee. Patient 1 said, "She gave me a muscle relaxer, it helped a little bit, because I had no pain medication." Patient 1 further said, on 11/26/11, the pain was so bad, she asked to go to the hospital. Review of Patient 1's Nurse's Notes 11/25/11 at 11 a.m., indicated, "Did c/o pain to knee and femur on left side." In an interview with licensed vocational nurse 2 (LVN 2) on 12/13/11 at 1:25 p.m., She said she would have expected a resident to receive a pain medication when she asked for one on 11/25/11. She acknowledged none was given. In an interview with LVN 1 on 12/21/11 at 2:20 p.m., Patient 1's nurses notes dated 11/25/11 were discussed. She said she did not give Patient 1 any pain medication when she complained of pain but should have.	A 179		

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A 179	Continued From page 4 Record review of the facility's "Medlocker Medication List" indicated Norco 10/325: 30 doses, in the drug inventory list. Review of the facility policy titled, "MEDICATION ADMINISTRATION" stipulated, "Medications shall be administered as ordered by a licensed nurse upon the order of a physician/licensed independent practitioner."	A 179		
A 394	T22 DIV5 CH3 ART3-72357(l) Pharmaceutical Service--Labeling and Storage (l) Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use. This Statute is not met as evidenced by: THIS RULE is not met as evidenced by: Based on inverview and record review the facility failed to insure drugs were not kept in stock for patient use after the expiration date when Patient 1's hydrocod/acetomin (Norco) (a medication used to relieve pain) 10/325 had an expiration date of 10/15/11 and was administered past that date. Findings: In a concurrent interview and record review with the director of nursing (DON) on 12/13/11 at 2:30 p.m. the facility drug card for Patient 1's hydrocod/acetomin (Norco) 10/325 with a delivery date of 12/26/10 was confirmed to have been for Patient 1. On the back of the bubble pack for the individual Norco pills was the expiration date 10/15/11. The facility's controlled Drug Record for Patient 1's hydrocod/acetomin	A 394		

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A 394	Continued From page 5 (Norco) 10/325 with a delivery date of 12/26/10, revealed Patient 1 received two Norco 10/325 on 10/17/11 at 7 a.m., one on 10/24/11 at 3 p.m., and 7 p.m., one on 11/2/11 at 3 p.m. and two on 11/3/11 at 7 p.m. The DON acknowledged these drugs should not have been administered past their expiration date of 10/15/11.	A 394		
A 822	T22 DIV5 CH3 ART5-72523(a) Patient Care Policies and Procedures (a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to follow their policies and procedures when; Findings: 1. Documentation of Patient 1's fall on 11/25/11 did not include the time of fall and physician notification. 2. The physician was not notified of Patient 1's change of condition when she returned from the emergency room on 11/26/11 nor was an assessment of her condition was done upon her return to the facility, and; 3. Documentation of Patient 2's fall on 11/22/11 did not include time of fall or physician and responsible party's notifications. 1. Patient 1 was a 58 year old, admitted to the facility on 9/30/09 with diagnoses including cerebral palsy (non-contagious and non-progressive motor problems that cause physical disability especially in the areas of body	A 822		

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A 822	Continued From page 6 movement) and muscle spasm (spasticity). Physician's Orders stipulated Patient 1 had mental capacity to make his/her own decisions. Review of Patient 1's Nurses Notes dated 11/25/11, indicated both the fall and physician notification occurred at 11 a.m. 2. Review of nurses notes 11/26/11 indicated Patient 1 went to the emergency room for further evaluation at 4:30 p.m. and returned to the facility 11/26/11 at 7:30 p.m. The notes also indicated a new order for Vicodin as needed, and the physician and responsible party were aware. Review of nurses notes 11/27/11 at 9:39 a.m., indicated Patient 1 was, "Currently resting in bed with knee wrapped." Review of Patient 1's acute care "ER Report" dated 11/26/11 indicated, the attending physician wrote, "...place her in an Ace wrap with instructions to follow up with primary care on Monday." In an interview with the DON on 12/20/11 at 1:55 p.m., she acknowledged there should have been an order for the use of the Ace bandage on Patient 1's left knee, and there was none. In an interview with licensed vocational nurse 3 (LVN 3) on 12/21/11 at 12:55 p.m., she acknowledged she should have documented the assessment for Patient 1 in the nurses notes, indicated she had an Ace bandage on her left leg when she returned from the emergency room, called the emergency room to get "report" on Patient 1 and call the physician for an order for the Ace bandage on the patient's left leg. In an interview with the DON on 12/20/11 at 1:55 p.m., she said, "It is a standard of practice to call any place that a patient has received treatment if they arrive back at our facility without a report of services." The DON acknowledged this should have been done for Patient 1 on 11/26/11. She further acknowledged there should have been an	A 822		

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A 822	Continued From page 7 order for use of the Ace bandage on Patient 1's left knee, and there was none. 3. Patient 2 was a 69 year old admitted to the facility on 11/2/11 with diagnoses including cerebral vascular accident, acute (when blood flow to an area of the brain stops) and muscle weakness. Physician's Orders stipulated Patient 1 had no mental capacity to make her own decisions. Review of Patient 2's nurses notes on 11/22/11 at 11:02 a.m. do not indicate the time of the fall or stipulate when, or if the physician and responsible party were notified. In an interview with the DON 12/13/11 at 11:40 a.m. she acknowledged the time of fall, physician notification and responsible party notification should have been documented by the nurse making the entry. In an interview with the registered nurse (RN 1) on 12/13/11 at 1 p.m., she said she did not document the correct time of patient 2's fall, or notification of the physician and responsible party in the clinical record, but should have. In a concurrent interview and record review with the Director of Nurses (DON) on 12/13/11 at 9 a.m., The facility's "NURSING/REHAB/ACCIDENT/INCIDENT LOG" dated November 2011 was reviewed. It indicated Patient 1 fell 11/25/11 at 9 a.m. and Patient 2 fell 11/22/11 at 6:25 a.m. The DON said the times listed on the facility form are accurate for when the accidents/incidents occurred. A review of the facility policy titled, "FALL PREVENTION PROGRAM" reviewed 7/14/11 stipulated, "Post fall...the licensed nurse will notify attending Physician and responsible party." and "Documentation will be maintained in the resident's medical record." A review of the facility policy titled, "CHANGE OF	A 822		

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A 822	Continued From page 8 CONDITION/NOTIFICATION" reviewed 12/1/10 stipulated; "POLICY": "A facility must inform the resident: consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident or incident, significant change, a need to alter treatments, or a ... ." "PHYSICIAN NOTIFICATION"; b. Urgent Issues: "i.e. fall with minor injury,...etc." ". Licensed nurse will call physician. If no response in 1 hour call again." "DOCUMENTATION"; "a. Licensed nurse will document date, time and pertinent details of incident and assessment in nursing notes. b. Licensed nurse will document time physician was contacted, response time and whether or not orders were received. c. Licensed nurse will document time family or interested party was contacted." "RECORD KEEPING"; "All documentation pertaining to change of condition shall be maintained in the resident's medical record ... ."	A 822		