accepted PJ 8-16-2011

PRINTED: 08/08/2011
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000022	A. BUILDING _____ B. WING _____	C 07/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR NURSING CENTER	900 NORTH CHURCH STREET LODI, CA 95240

(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) COMPLETE DATE
A 000	Initial Comments The following represents the findings of the California Department of Public Health during the investigation of complaint #CA00276277. Representing the Department of Public Health: HFEN 1672/17121 The inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.	A 000	**DISCLAIMER STATEMENT** Preparation, submission and implementation of the Plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
A 166	T22 DIV5 CH3 ART3-72311(a)(2) Nursing Service--General (a) Nursing service shall include, but not be limited to, the following: (2) Implementing of each patient's care plan according to the methods indicated. Each patient's care shall be based on this plan. This Statute is not met as evidenced by: Based on observations, interview and clinical record review, the facility failed to implement Patient 1's plan of care when Patient 1 was observed in bed at an angle less than 90° (degrees) with no assistance provided during breakfast. Findings: On 7/26/11 at 7:36 a.m., an unannounced visit was conducted at the facility to investigate a complaint related to Quality of Care. The facility was toured and patients were observed in their rooms and the dining room. Patient 1 was observed in bed with the head of the bed at less than 30° with an uncovered breakfast tray on the bedside table.	A 166	**A 166** **a)** The corrective action to be accomplished for the patient identified to have been affected by the deficient practice is: immediate re-education of the C.N.A. assigned to this resident. Resident was offered a fresh, new meal with assistance. **Completed 7/26/11** b) All Residents needing assistance with meals have the potential for being affected. c) The immediate measures and systemic changes put into place to assure that the deficient practice does not recur: 1) Inservice to C.N.A's regarding: a) Proper positioning of residents for meals. Set up including adding condiments of residents' preferences. **Completed 8/16/11** b) Assuring call lights are within reach when leaving a resident in room. **Completed 8/12/11**	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 8-15-11

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A 166	Continued From page 1 From 7:36 a.m. to 8:20 a.m., Patient 1 was in the same position with the breakfast tray on the bedside table uncovered. At 8:20 a.m., a Certified Nursing Assistant (CNA) walked into Patient 1's room and asked Patient 1 if he was finished with his meal. (The meal had not been touched.) The CNA re-positioned Patient 1 upright to a position of about 30° (still less than 90°). Patient 1 was not provided with any assistance with the meal. On 7/26/11 at 8:32 a.m., Patient 1's clinical record was reviewed. The care plan with a problem "Self-Care Deficit Related To: Eating" dated 1/18/11 with a re-evaluation date of 10/11 had the following interventions: "Eating assistance required: One person physical assist." Another care plan with a problem "Swallow Precautions" dated 9/24/10 with a re-evaluation date of 10/11 contained the following under the heading "Problem/Need": "Sit at 90° angle; Alternate liquids/solids; tuck chin..." The approach for this problem included the following: "Elevate HOB (head of bed) min (minimum) of 80° during meals and for 30 minutes after. Instruct resident to chin tuck (tip head forward)." On 7/26/11 at 8:39 a.m., an interview was conducted with the Director of Staff Development (DSD). When questioned about Patient 1's positioning for meals, the DSD stated she did not know, and went into Patient 1's room. While in the room, the DSD stated Patient 1's angle of positioning was at "15-20°" and moved Patient 1 to 45°. The DSD provided assistance (putting straw into the juice and held it for Patient 1) and Patient 1 drank some of the juice; placed Patient 1's call light within reach; and prepared Patient 1's coffee by putting sugar in it after the approval from Patient 1. When questioned about the care	A 166	(d) Charge Nurse's round during residents meals to assure proper feeding and positioning of all residents. Supervisor rounds audit residents positioning for meals and report problems to the DON for assessment. Any trends will be referred to the Quality Assurance Committee (QAA). QAA reviews and provides feedback and/or suggestions for improvement Routine rounds are conducted by the deparment heads. Audits for call lights within reach will be analzyed by the Executive Director. Any trends will be referred to the Quality Assurance Committee (QAA). QAA reviews and provides feedback and/or suggestions for improvement **Completed 7/26/11**	

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A 166	Continued From page 2 provided by the DSD, the DSD went stated this should have been done by the CNA and went to find the CNA responsible for providing care to Patient 1. On 7/26/11 at 8:42 a.m., an interview was conducted with the DSD and CNA 1. CNA 1 stated while she was the CNA assigned to Patient 1, she did not set him up for his breakfast. The DSD stated Patient 1's "set-up" was not done. It appeared that the cover lids on the foods were removed. But, patient 1 was not positioned according to the care plan recommendations, the call light was not in reach and his coffee was not prepared to his liking.	A 166	(d) Charge Nurse's round during residents meals to assure proper feeding and positioning of all residents. Supervisor rounds audit residents positioning for meals and report problems to the DON for assessment. Any trends will be referred to the Quality Assurance Committee (QAA). QAA reviews and provides feedback and/or suggestions for improvement Routine rounds are conducted by the deparment heads. Audits for call lights within reach will be analzyed by the Executive Director. Any trends will be referred to the Quality Assurance Committee (QAA). QAA reviews and provides feedback and/or suggestions for improvement **Completed 7/26/11**	
A1192	T22 DIV5 CH3 ART6-72631(b) Signal Systems (b) Detachable extension cords shall be readily accessible to patients at all times. This Statute is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Patient 1's call light system was within reach of the patient to ensure his care needs could be addressed. Findings: On 7/26/11 at 8:39 a.m., an interview was conducted with the DSD. When questioned about Patient 1's positioning for meals, the DSD stated she did not know, and went into Patient 1's room. While in the room, the DSD stated Patient 1's angle of positioning was at "15-20°" and moved Patient 1 to 45°. The DSD provided assistance (putting straw into juice and held it for Patient 1) and Patient 1 drank some of the juice;	A1192		

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A1192	Continued From page 3 placed Patient 1's call light within reach; and prepared Patient 1's coffee by putting sugar in it after the approval from Patient 1. When questioned about the care provided by the DSD, the DSD went stated this should have been done by the CNA and went to find the CNA responsible for providing care to Patient 1. On 7/26/11 at 8:42 a.m., an interview was conducted with the DSD and CNA 1. CNA 1 stated while she was the CNA assigned to Patient 1, she did not set him up for his breakfast. The DSD stated Patient 1's "set-up" was not done. It appeared that the cover lids on the foods were removed. But, patient 1 was not positioned according to the care plan recommendations, the call light was not in reach and his coffee was not prepared to his liking. According to the facility's 2006 policy "Call Light, Use of" the following procedure was in place: "8. When providing care to residents be sure to position the call light conveniently for the resident to use... 11. Be sure all call lights are placed on the bed at all times, never on the floor or bedside table."	A1192		