STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555459	A. BUILDING _____ B. WING _____ accepted 1/24/14 LK	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAMERCY COURT	2200 GRAMERCY DRIVE SACRAMENTO, CA 95825

(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 for the investigation of complaint #CA00381341. Representing the Department of Public Health: HFEN 32525 HFEN 31701 Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review, the facility failed to ensure 1 of 3 sampled residents (Resident 1) was free from accidents when Certified Nursing Assistant 1(CNA 1) transferred Resident 1 from the bed to the wheelchair without a second staff person and lift device as indicated in his plan of care. This failure resulted in multiple skin tears and moderate to severe pain to Resident 1's right foot.	F 323	**How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ▪ Resident 1 transfers shall be conducted with 2 staff members and use of a mechanical lift (Hoyer). **How the facility will identify other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ All residents needing transfer with a Hoyer lift have potential to be affected by this practice. ▪ All residents who need to be transferred by a Hoyer lift, shall be transferred with a Hoyer lift by 2 staff members.	2/15/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Henry Brumley	Administrator	1/29/14

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.

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F 323	Continued From page 1 Findings: Review of Resident 1's admit sheet indicated he was admitted on 5/19/2009 with multiple diagnoses including muscle weakness and osteoarthrosis of the hand (degeneration of the joints). The quarterly Minimum Data Set (MDS, an assessment tool) dated 9/25/13 reflected Resident 1 had short-term and long-term memory problems and required modified independence for daily decision making. The MDS also reflected that Resident 1 was totally dependent on staff for transfers to chair, bed and wheelchair and required two or more persons for physical assistance. A review of Resident 1's care plan for falls, dated 3/28/2012, under "Problem" indicated in part, Resident 1 was at risk for falls and injury related to history of falls, resistiveness to care, agitation at times, and impaired mobility. Under "Goal" indicated a long term target date as 12/27/2013, and reflected Resident will remain free from Injury. Under the care plan "Approach" with a start date of 04/22/2012, indicated, "MECHANICAL LIFT TRANSFERS with two staff assist." During an observation on 12/27/13 at 11:57 a.m., Resident 1 was observed sitting in wheelchair in his room as the Assistant Director of Nursing (ADON) completed a dressing change to the toes on his right foot. A review of a Progress Note, dated 12/15/13 at 16:47, written by a Registered Nurse, indicated, "When the CNA was giving the resident [Resident 1] a shower at 1530, she noticed that there were skin tears on the toes of his R [right] foot. The	F 323	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; ▪ Nursing personnel in-serviced on facility Hoyer Lift P & P by the Director of Staff Development on 12/19/13, & 1/22/14 – 1/27/14. ▪ All resident "Communication Care Forms" posted within a resident closet have been audited/updated on how to transfer resident. ▪ Resident requiring mechanical lift transfers have been updated on the resident Communication Care form. ▪ CNA's in-serviced to review their assigned resident Communication Care form upon start of shift by the Director of Staff Development on 1/22/14 – 1/27/14. ▪ Care Plan approaches requiring staff members to use a Hoyer for transfers have been audited and updated. ▪ Care Plan approaches identified as Hoyer lift for transfers have been added to the residents Matrix Profile button in the Point of Care to CNA's.	

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F 323	Continued From page 2 CNA does not know how the skin tears occurred, she thinks it may have happened during transfer from his room to shower room. Nurse and nursing supervisor assessed his skin tears, there are 4 superficial skin tears noted..." During an interview on 12/27/13 at 12 p.m., with CNA 2, he indicated Resident 1 required 2 person assistance to transfer to bed or wheel chair using a hoyer lift. When CNA 2 was questioned where he would find information on Resident's 1 transfer needs he stated, "I just know because I work with him."[indicating he was Resident's 1 regular CNA]. During an interview with CNA 1 on 12/31/13 at 10:37 a.m., she stated, "I transferred patient [Resident 1] alone to wheel chair...I did not know he uses hoyer lift." CNA 1 further stated, "he might have hit himself during transfer...there was blood on the floor...I saw his toes bleeding in the shower room." During an interview with the Director of Nursing (DON) on 1/2/14 at 11:45 a.m., she indicated CNAs are to refer to the charge nurse if they are not sure about a resident care issue. She further indicated she had updated a communication tool for CNAs and stated, "We need something more formal for CNAs to refer to." The DON indicated there was no policy related to individual resident reports specifically for CNAs and stated, "I am working towards improving the systems."	F 323	▪ CNA's have been in-serviced to check their assigned resident Matrix Profile care at beginning of shift to identify which of their resident require a Hoyer lift for transfers by the Director of Staff development on 1/22/14 – 1/27/14. ▪ The Matrix POC Profile tab has been added to the orientation training program. ▪ Residents requiring Hoyer lifts for transfers have been identified on the 24hr nursing report. ▪ Licensed nurses in-serviced on informing CNA's at beginning of shift which of their assigned resident requires a Hoyer lift by the Director of Staff Development on 1/22/14 – 1/27/14 **How the facility plans to monitor its performance to make sure solutions are sustained:** • DON/ADON and/or assigned personnel shall be responsible to ensure Charge Nurses are informing CNA which assigned residents are mechanical lifts. . • In-services shall be forwarded to the monthly Quality Assurance & Assessment Committee until the IDT substantiates compliance.	
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	F 329		

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F 329	Continued From page 3 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 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure 1 of 3 sampled residents (Resident 1) was free from unnecessary medications when Resident 1 had several physician orders for medications that contained acetaminophen which increased the potential risk of exceeding 4 grams in 24 hours. There were no safeguards in place to prevent Resident 1 from receiving an excessive dose of acetaminophen. Findings:	F 329	F 329 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ▪ Pharmacy consultant reviewed Resident 1 acetaminophen orders. ▪ Resident 1 duplicate acetaminophen orders were reviewed and reduced to a total of <4gms/24 period. ▪ Resident 1 had order on 9/11/11 for Tylenol (Acetaminophen) NTE 4000mg/24hrs from all sources. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; ▪ All residents with multiple acetaminophen orders have potential to be affected by this practice. ▪ All residents with duplicate acetaminophen orders were audited and duplicate orders removed as needed to ensure acetaminophen are NTE 4gm/24hrs from all sources. ▪ All acetaminophen orders state NTE 4/gm/24hrs from all sources.	2/15/14

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F 329	Continued From page 4 A review of Resident 1's admit sheet indicated he was admitted on 5/19/2009 with multiple diagnoses including muscle weakness and osteoarthrosis (degeneration of the joints). The quarterly Minimum Data Set (MDS, an assessment tool) dated 9/25/13 reflected Resident 1 had short-term and long-term memory problems and required modified independence for daily decision making. The MDS also reflected that Resident 1 had not received any as needed (PRN) pain medication during the 7 days look back period. The clinical record for Resident 1 included the following physician orders: - 3/27/2013: hydrocodone-acetaminophen [pain medication] 7.5/325 mg [milligrams, unit of measurement] per 15 milliliters (ml) : give 10 ml every 6 hours as needed for pain. - 5/1/2013: hydrocodone-acetaminophen [pain medication] 7.5/325 mg (milligrams) per 15 milliliters (ml) : give 10 ml for pain with orange juice or soda twice a day. - 5/19/2009: Acetaminophen 325 mg: 2 tablets (650 mg total) every 4 hours as needed for mild pain. - 8/24/11: Acetaminophen 325 mg: 2 tablets (650 mg total) for low grade temperature as needed(PRN) PRN 1, PRN 2, PRN 3. - 8/24/11: Acetaminophen 325 mg: 2 tablets (650 mg total) for MILD PAIN once a day as needed. - 11/27/2013: Acetaminophen elixir[liquid]; 160 mg/5 ml: give 20 ml twice a day for pain.	F 329	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; ▪ All new physician ordered medication orders containing acetaminophen shall be reviewed/audited to ensure total acetaminophen orders do not exceed a total of 4gm/24hr. ▪ Medical records shall conduct monthly audits of residents receiving acetaminophen orders and forward to DON. ▪ DON/ADON and/or assigned personnel shall review medical record acetaminophen audits to confirm orders do not exceed 4gm/24hrs. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; ▪ DON shall forward reviewed/audited Medical Record acetaminophen medication audits to the Quality Assurance Assessment Committee until the IDT substantiates compliance.	

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F 329	Continued From page 5 - General order 9/11/2011-open ended Acetaminophen NTE [not to exceed] 4000 mg/24 hours from all sources. According to package insert for Tylenol [another name for acetaminophen] Liver Warning: This product contains acetaminophen. The maximum daily dosage for this product is 10 tablets (3,250 mg) in 24 hours for adults...Severe liver damage may occur if: adult takes more than 4,000 mg of acetaminophen in 24 hours ..." [Source:http://WW/products/Tylenol-regular-strength-tablets]. During a telephone interview with the Assistant Director of Nursing (ADON) on 12/31/13 at 9:26 a.m., she was asked to review Resident's 1 physician orders and she acknowledged Resident 1 had the potential risk to receive greater than 4,000 mg of acetaminophen in 24 hours. She further stated, "these are so many we need to clean it up."[referring to medications containing acetaminophen ordered for Resident 1]. There was no documented evidence that the licensed nursing staff were ensuring Resident 1 did not receive an excessive dose of acetaminophen by "counting." In an interview with the Director of Nursing (DON) on 1/2/31 at 11:45 a.m. to establish the mechanisms in place to ensure Resident 1 did not receive more than 4,000 mg of acetaminophen in 24 hours, she indicated the ADON had discussed this with her and stated, "It's been fixed."	F 329		