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	055510	A. BUILDING _____ B. WING _____	C 05/30/2012

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GOLDEN LIVINGCENTER - REDDING	1836 GOLD STREET REDDING, CA 96001

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F 000	INITIAL COMMENTS AMENDED The following reflects the findings of the California Department of Public Health during an Abbreviated Standard Survey for Complaint/Entity Reported Incidents: 298360, 302746, 303781, and 305157 The 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 Public Health: HFEN, 25461 and HFEN, 26842 For Complaint 298360, one deficiency was written at F-353. No deficiencies were issued for entity reported incidents: 302746, 303781, and 305157.	F 000	**DISCLAIMER STATEMENT** Preparation, submission and implementation of this Plan of Correction do 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 sate and federal regulatory requirements. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.	F 353	**CA 298360** **F 353** **483.30(a) SUFFICIENT 24-HOUR NURSING STAFF PER CARE PLANS** The facility failed to provide sufficient staffing to ensure residents were consistently provided quality care and nursing services.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nel A. Long — TITLE: RN, DNS — (X6) DATE: 6/20/2012

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.

Nate Eduds — Executive Director — 7/12/12

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F 353	Continued From page 1 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty This REQUIREMENT is not met as evidenced by. Based on observation, interview, and facility document review, the facility failed to provide sufficient staffing to ensure residents were consistently provided quality care and nursing services when: Thirteen of 13 residents (Residents 1 - 13) regularly scheduled to be showered on Friday mornings did not receive their morning showers on 2/3/12 Eleven of 23 residents (Residents 11 and Residents 14 - 23) scheduled for Restorative Nursing Assistant (RNA) services during February 2012 did not receive RNA services, as scheduled The failure to provide scheduled care and services had the potential of jeopardizing residents' ability to attain and maintaining their highest level of function, as well as jeopardizing their sense of comfort and wellbeing Findings On 2/14/12 at 9:50 am an onsite investigation	F 353	**Question 1:** 1)Residents 1, 4, 5, 6, 7, 8, 11, 12 & 13 were affected, related to having no documented evidence of not receiving their morning showers on 2/03/2012. All residents were provided shower within two days or on next shower day if they preferred. Residents 2, 3, 9 & 10 are no longer in the facility. 2) Residents 11, 14, 15, 16, 17, 18, 19, 21, & 22 were affected, related to not receiving RNA services as scheduled. Residents have been receiving their RNA services as scheduled. Residents 20 & 23 are no longer in the facility. The facility expedited contracts with two registries to have access for registry C.N.A's on 2/4/12 to meet the residents' needs.	

Executive Director 6/12/12

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F 353	Continued From page 2	F 353	**Question 2:**	

was initiated in response to a complaint that the facility was short staffed the morning of 2/3/12. The investigation initially included review of the census and staffing records for 2/3/12. It was confirmed that on the morning of 2/3/12, the facility was short staffed. The day started with four Certified Nursing Assistants (CNA's) assigned to care for 78 residents. Each CNA was required to try and meet needs and provide care for between 15 and 18 residents that morning.

1. Tour of the facility on 2/14/12 at 11 am included observations of and interviews with residents. Resident 20 was an awake and alert resident that remembered the facility being extra short staffed the morning of 2/3/12, stating the day had started with only four CNA's. The resident did not remember anything particular about 2/3/12, other than being short staff but added, "They're short a lot."

Facility document review on 2/14/12 included review of the scheduled care and services residents were to have received on 2/3/12. The shower logs revealed that 13 residents (Residents 1 - 13), were scheduled for morning showers on Friday 2/3/12. None of the 13 residents were given showers that morning. Residents 1, 2, 9, 10, and 12 did not get showered. Residents 3, 4, 5, 6, 7, 8, and 13 were given partial baths, and Resident 11 was given a shower later that evening. The review period for the same 13 residents was expanded to cover a 14 day period, 1/31/12 - 2/13/12. During the 14 days reviewed, Residents 3, 5, and 13 received 1 shower. Residents 1, 2, 6, 7, 8, 9, 10, 11, and 12 each received two showers, and Resident 4 received four showers.

All residents have the potential to be affected.
1) Shower schedules will be documented daily on C.N.A. assignment sheets and also on C.N.A Kardex.
Facility will continue to utilize registry staff as needed to ensure that staffing levels of C.N.A.'s are appropriate to meet resident needs for showers and RNA services are provided as scheduled.

2) CNA scheduler, licensed nurses and IDT reviewed and revised the system of managing arrangement of resident appointments outside of the facility, so that RNA's would not be pulled off from their usual assigned tasks.

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F 353	Continued From page 3	F 353	**Question 3:** 1) Facility administration has reviewed staffing ratios and has hired adequate staff to ensure and RNA services are provided as scheduled. Nursing staff members were provided education regarding policies on attendance, tardiness, early departures, and call-ins. . Showers are assigned every shift to CNA's by the Licensed Nurse. Licensed Nurses compare Care Tracker documentation to shower assignments to ensure completion q am. Showers not completed will be provided before end of day or as resident requests. 2) Appointments are now discussed in the weekday Clinical Start Up meetings to ensure that appropriate escorts and transportation arrangements are prepared at least 48hours in advance to prevent RNA's from being pulled from their assignments.	

In an interview and record review with the Assistant Director of Nursing Services (ADNS) on 2/14/12 at 3 pm, she reviewed the 2/3/12 assignment sheets and shower logs. She confirmed staffing problems on 2/3/12, stating that several staff had called in sick. At 4 pm, the Director of Nursing Services (DNS) joined the conversation and confirmed that multiple staff had called in sick.

On 2/15/12 at 8:30 am, CNA's that had worked the morning of 2/3/12 were interviewed. CNA-A stated she was usually assigned the same group of residents each shift along with a second CNA, however on the morning of 2/3/12, staffing was short and she had to cover the group by herself. She described her typical morning routine as starting at 6:30 am, with a 30 - 40 minute window, to get everyone up; faces washed, hands cleaned, and oral care done, before taking the residents into the dining room for their breakfast. At 7:10 am, CNA-A was scheduled for dining room duty and needed to be in the dining room to assist residents and pass coffee. CNA-A remembered the morning of 2/3/12 as being, "Really bad." She stated the day started with only four CNA's for the entire facility when normally 7 - 8 CNA's would have been scheduled. CNA-A had 15 residents to care for that morning.

Other care and services to be provided were reviewed with CNA-A. CNA-A reviewed the shower/bathing schedules and stated that all residents were scheduled for at least two showers per week. Residents were scheduled for showers either on, Mondays and Thursdays, Wednesdays and Saturdays, or Tuesdays and

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F 353	Continued From page 4 Fridays. The shower logs were reviewed with CNA-A. She indicated that all residents were scheduled for at least two showers per week. CNA-A explained a partial bath could be given if a resident needed cleaning between shower days, if a resident were too ill to shower, or if a resident refused to shower. But all residents were supposed to be showered at least two times per week. CNA-A expressed concern when she reviewed the shower logs and saw the number of days showers were not given. In the two week period reviewed, for residents scheduled to have Tuesday/Friday showers, only 1 resident (Resident 4) had received four showers. CNA-A stated that in the past she had come back from being off for two days to find Resident 10 in the same clothes she had left her in. She went on to say that 2/3/12 was unusual, "But we've had other days like that." On 2/15/12 at 10:45 am, CNA-B was interviewed. CNA-B remembered the morning of 2/3/12, she stated she had 18 residents that morning. CNA-B stated that there were times recently when there were more licensed nurses working than CNA's. CNA-B stated the licensed nurses passed meds and covered the desk, but for the most part did not do patient care. She explained that residents often did not get their scheduled showers when they were short staffed. CNA-B shared that she now worked primarily as a CNA even though she had been trained and had worked as an RNA (restorative nursing assistant / responsible for assisting residents with walking and general strengthening exercises). As	F 353	**Question 4:** CNA Scheduler with DNS oversight is responsible for ensuring that there is adequate staffing. The Licensed Nurse will review shower sheets to ensure shower have been completed. DNS will randomly review 8 shower sheets a week and compare them to Care Tracker to ensure compliance. 2) SSD/designee is responsible for making resident appointments, and communicating to licensed nurses. Any on-going non-compliance with staffing will be bought to ED and QAA committee for recommendations. **Question 5:** Compliance date is 6/21/12	

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an RNA, she stated, she was pulled to the floor so often (to cover as a CNA) she could not get her RNA work done.

In a telephone interview on 2/15/12 at 4:45 pm, CNA-C stated she remembered the morning of 2/3/12 and confirmed that the staffing was unusually bad. She was aware that an RNA had been pulled to help them on the floor. She acknowledged not getting any showers done that day stating, "It really makes you feel bad."

2. RNA record review on 2/15/12 indicated that for the month of February 2012, eleven of 23 residents (Residents 11 and Residents 14 - 23) scheduled for RNA services were not provided regularly scheduled RNA sessions. Not one of the 11 residents received RNA services on 2/3/12. Documentation on the therapy treatment plans indicated that services were not provided because the RNA's were, "pulled to the floor," to cover CNA duties. Further record review indicated multiple days of scheduled RNA care and services were not provided during February 2012.

On 2/15/12 at 9:45 am, RNA-D was interviewed. She stated that she had been a CNA for six years and had been trained and working as an RNA for the last two to three months. She explained that there were usually 2 RNA's on the schedule seven days a week. She went on to explain that they, the RNA's, were often pulled to the floor to assist with CNA duties.

In an interview with the DNS on 2/15/12 at 12:15 pm, she stated that if RNA's could not provide RNA service they were supposed to inform the

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charge nurse, so the therapy could be re-scheduled. She stated that residents were not supposed to have set days for RNA services but rather be scheduled by frequencies (three times per week) that way they could be re-scheduled and still meet the treatment plan.

On 2/15/12 at 12:30 pm, the Rehabilitation Department Director (Rehab Director) was interviewed. She explained that RNA's were CNA's that were trained by the therapists to assist residents with therapy treatment plans. The treatment plans, as explained by the director, were designed by the therapists, so that once a resident was discharged from the therapy department they would still be able to maintain and/or improve their functional skill level. Treatment plans might include exercises such as, omnicycle time, upper body exercises, and assisting the resident with walking. All the exercises were designed to assist a resident in maintaining and/or improving their endurance, strength, and independence. The Rehab Director stated that without regularly scheduled therapy, the residents were at risk for functional decline.

In an interview and record review with RNA-D on 2/16/12 at 10:50 am, reviewing the assignment sheet and RNA records, she stated, "I couldn't remember the date, but remember it was the worst day ever." She continued to explain that she had come in on 2/3/12 and was pulled to help with CNA duties. Another CNA came in around 11:30 am, at which time she was able to return to her RNA duties. She thought the other RNA scheduled on 2/3/12 was left to assist with CNA duties.

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On 2/16/12 at 12:30 pm, RNA-E was interviewed. She stated she had been a CNA for 10 years and an RNA for two to three years. She clearly remembered being pulled to the floor on both 2/2/12 and 2/3/13, as well as several other days. She stated, "If Residents miss too many RNA sessions then they decline and have to return for physical therapy services."

Review of the assignment sheets with RNA-E, confirmed that RNA-E was pulled from her RNA duties to provide patient care as the fourth CNA on 2/3/12 am. Review of the RNA log book confirmed that Resident 11 and Residents 14 - 23, were scheduled to receive RNA services on 2/3/12 and that RNA-E was originally assigned that group. None of the 11 residents assigned to RNA 5 on 2/3/12 received their scheduled RNA services.

RNA record review continuing on 2/16/12 indicated that for the month of February 2012, Resident 11 and Resident 21 missed two days of scheduled RNA services because the RNA's were, "pulled to the floor." Residents 15, 16, 17, 19, 20, 22, and 23, missed six scheduled RNA sessions because the RNA's were, "pulled to the floor." Resident 14 and Resident 18, both missed seven days of their scheduled RNA sessions in February because their RNA's were, "pulled to the floor."